

## **TRUST SUBMISSION FORM FOR RANITIDINE CLAIMS PROCESS**

This ranitidine trust submission form (this “**Ranitidine Trust Submission Form**”) must be completed by each Ranitidine Claimant seeking an Award from the Endo Ranitidine Sub-Trust (the “**Ranitidine Trust**”) on a Ranitidine Claim.<sup>1</sup>

FAILURE TO SUBMIT THIS RANITIDINE TRUST SUBMISSION FORM AS PROVIDED IN THE RANITIDINE CLAIMS PROCESS AND THE RANITIDINE TRUST AGREEMENT MAY CAUSE THE RANITIDINE CLAIM TO BE DEEMED NON-COMPENSABLE UNDER THE RANITIDINE CLAIMS PROCESS AND THE RANITIDINE TRUST AGREEMENT.

### **Instructions:**

Follow the instructions of each section carefully to ensure that your Ranitidine Trust Submission Form is submitted correctly. If any section does not pertain to your claim, leave it blank. Except as otherwise indicated, all words shall be given their ordinary, dictionary meaning. Submitting this Ranitidine Trust Submission Form does not guarantee that you will receive payment from the Ranitidine Trust or that your Claim will be Allowed. Whether you will receive payment depends on whether you provide the required submissions, as set forth in the Ranitidine Claims Process and whether your claim meets the eligibility requirements set forth in the Ranitidine Claims Process – the “**Review Process.**”

This Ranitidine Trust Submission Form allows you to elect for your claim to be submitted to an “**Extraordinary Review**” process which will remove your claim from the streamlined Ranitidine Claims review process and make your claim eligible for the Ranitidine Trustee, in their discretion, to award additional compensation to Ranitidine Claimants who present proof of injury or loss of a type or severity not otherwise captured by the standard review process. The Extraordinary Review process may take significantly more time for the Ranitidine Trustee to conduct than the Review Process discussed above.

Should you disagree with the ruling of the Ranitidine Trust with respect to the value of your Ranitidine Claim, you may file a lawsuit in the tort system against the Ranitidine Trust pursuant to Section 4.6.1 of the Ranitidine Claims Process. You may litigate in court only with respect to a Ranitidine Claim held against one or more Debtors, and may not litigate other Ranitidine Claims. Any final judgment you obtain in the tort system against the Ranitidine Trust will be subject to the Maximum Amount cap set forth in the Ranitidine Claims Process.

If you choose to litigate your claim in the tort system, the Ranitidine Trust will be able to raise any available defenses to your claim, including any defenses based on whether your claim was timely filed under the applicable statute of limitations.

Each Ranitidine Claimant is responsible for satisfying any liens that health insurance companies, government entities (including Medicare and Medicaid), or any other third party may have against any distributions that may be issued by the Ranitidine Trust. By submitting this Ranitidine Trust Submission Form and choosing to liquidate your Claim through the Ranitidine Claims Process, you understand that the Ranitidine Trust may enter into a lien resolution program (“**LRP**”) and, if the Ranitidine Claims Process does enter into a LRP, you are deemed to consent to the LRP and the Ranitidine Trust’s release of information provided in connection with your Ranitidine Claim as required under the LRP to identify

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<sup>1</sup> Capitalized terms used but not defined herein have the meanings ascribed to them in the Ranitidine Claims Process attached as **Exhibit 1** to the Ranitidine Trust Agreement (the “**Ranitidine Claims Process**”), or, if not defined therein, then the meanings ascribed to them in the Plan, the Confirmation Order, or the Ranitidine Trust Agreement. A copy of the Ranitidine Trust Agreement may be obtained by visiting [www.EndoGUCTrust.com](http://www.EndoGUCTrust.com).

any liens that may be asserted against a distribution based on the Ranitidine. If any liens are identified against your Allowed Eligible Ranitidine Claim, the Ranitidine Trust may reduce distributions on account of your Allowed Eligible Ranitidine Claim by the amount required to satisfy the lien(s).

By signing this form, you agree that all information that you provide in this Ranitidine Trust Submission Form may be provided to insurers or other entities that may have payment obligations in connection with your Ranitidine Claim, solely to the extent necessary to pursue or obtain payment for your Ranitidine Claim and subject to appropriate confidentiality protections.

Ranitidine Trust Submission Form Submission: You may submit this form by uploading it as an attachment to your Trust Submission Form and submitting it electronically as described at [www.EndoGUCTrust.com](http://www.EndoGUCTrust.com). If you are submitting your Trust Submission Form by mail or hand delivery, you may obtain a hard copy of this Ranitidine Trust Submission Form to attach to your Trust Submission Form by (i) emailing [EndoInquiries@stretto.com](mailto:EndoInquiries@stretto.com) (please reference “Endo GUC Trust – Ranitidine Trust Submission Form” in the subject line) or (ii) calling 855-451-4091 (toll-free) or 714-716-1858 (international).

**PART ONE: PERSONAL INFORMATION OF RANITIDINE CLAIMANT**

Please fill out only **one** of the following sections (Section 1.A or 1.B).

- If you hold a Ranitidine Claim arising from your own experience with an Eligible Debtor Product<sup>2</sup> (or if such holder is alive and you are completing this form as their representative), fill out Section 1.A.
- If you hold a Ranitidine Claim arising from a deceased person’s experience with an Eligible Debtor Product (or you are completing this form on behalf of such a holder as their representative), fill out Section 1.B.

**Section 1.A: If you hold a Ranitidine Claim arising from your own experience with an Eligible Debtor Product (or if such holder is alive and you are completing this form as their representative), then the term “Claimant” in this Ranitidine Trust Submission Form refers to the person prescribed the Eligible Debtor Product, whether that is you or the person you represent. Please fill out the information below:**

**Claimant’s Name:** \_\_\_\_\_

**Claimant’s Date of Birth:** \_\_\_\_\_

**Claimant’s Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Claimant’s Social Security Number:** \_\_\_\_\_  
(or Taxpayer ID)

**Claimant’s Telephone Number:** \_\_\_\_\_

**Representative Name (if applicable):** \_\_\_\_\_

**Legal Authority for Representative (if applicable):** \_\_\_\_\_  
(e.g., POA, Legal Guardian, Conservator)

**Section 1.B: If you are filing a Ranitidine Claim for a deceased person with a claim due to the deceased person’s prescription of an Eligible Debtor Product, or you are completing this form as the representative of an individual with a claim for a deceased person’s prescription of an Eligible Debtor Product, then the term “Claimant” in this Ranitidine Trust Submission Form refers to the**

<sup>2</sup> As defined in the Ranitidine Claims Process, “**Eligible Debtor Product**” means any product manufactured by the Debtors containing Ranitidine.

**person with a Ranitidine Claim on behalf of the individual prescribed an Eligible Debtor Product. Please fill out the information below:**

**Name of Deceased Person Prescribed an Eligible Debtor Product:** \_\_\_\_\_

**Date of Birth of Deceased Person Prescribed an Eligible Debtor Product:** \_\_\_\_\_

**Date of Death:** \_\_\_\_\_

**Cause of Death:** \_\_\_\_\_

**Social Security Number for Deceased Person Prescribed an Eligible Debtor Product:** \_\_\_\_\_

(or Taxpayer ID)

**Claimant's Name:** \_\_\_\_\_

**Claimant's Address:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Claimant's Relationship to the Deceased Person Prescribed an Eligible Debtor Product:** \_\_\_\_\_

**Claimant's Telephone Number:** \_\_\_\_\_

**Representative Name (if applicable):** \_\_\_\_\_

**Legal Authority for Representative (if applicable):** \_\_\_\_\_

(e.g., POA, Legal Guardian, Conservator)

If a Court has appointed you as Executor, Administrator or Personal Representative of the Deceased Person's Estate, then submit the Court Order so appointing you along with your Ranitidine Trust Submission Form. If a Court has not appointed you as Executor, Administrator, or Personal Representative of the Deceased Person's Estate, then execute and submit the Heirship Declaration attached hereto as **Exhibit B.**

**PART TWO: ELECTION FOR THE “EXTRAORDINARY REVIEW” CLAIMS PROCESS**

(Complete this part only if you elect for your Ranitidine Claims to be reviewed under the “Extraordinary Review Process.” You may choose to have your claim evaluated under the Extraordinary Review Process if, after reviewing the Scheduled Values set forth in Section 4.1 of the Ranitidine Claims Process, you believe your Ranitidine Claim deserves additional compensation due to injury or a loss of a type or severity not otherwise captured by the Ranitidine Claims Process. If you do not wish to elect for the Extraordinary Review Process, skip this Part Two).

If you would like to forfeit all rights to have your Ranitidine Claims evaluated under the standard Review Process in the more efficient, streamlined review and instead wish to submit your Ranitidine Claim to the Extraordinary Review process, please select the box below.

Mark the following box **only if** you **elect for your Ranitidine Claim to be submitted to the Extraordinary Review process:**

I elect for my Ranitidine Claim to be reviewed under the Extraordinary Review Process

Holders of Ranitidine Claims who elect for their claim to be reviewed under the Extraordinary Review Process must still complete all Parts of this Ranitidine Trust Submission Form. Holders of Ranitidine Claims who wish to have their claim reviewed under the ordinary Review Process may leave this Part Two blank.

**PART THREE: PRESCRIPTION AND USE OF AN ELIGIBLE DEBTOR PRODUCT**

Identify the Eligible Debtor Product that the individual who is the subject of this Ranitidine Claim was prescribed. *Include evidence of the prescription or purchase and any Qualifying Cancer<sup>3</sup> when submitting this Ranitidine Trust Submission Form.*

It is important for this Part Three that you have ***executed and submitted the HIPAA release form*** attached hereto as **Exhibit A** to ensure the Ranitidine Trustee can access and review the medical records that support your claim.

Name of Eligible Debtor Product Used or Prescribed: \_\_\_\_\_

Date of Prescription or Purchase:	Date(s) of Any Subsequent Qualifying Cancer Diagnosis:	Length of Use of the Eligible Debtor Product (in months):	Frequency of Use of the Eligible Debtor Product (per week)
_____	_____	_____	_____

<sup>3</sup> As defined in the Ranitidine Claims Process, “**Qualifying Cancer**” means any of the following cancers: (a) Liver, (b) Gastrointestinal/Stomach, (c) Bladder, (d) Pancreatic, and (e) Esophageal.

## **PART FOUR: RANITIDINE CLAIMANT INJURIES**

WARNING: IF YOU DO NOT CHECK ANY DIAGNOSES ON THIS LIST, THEN YOUR RANITIDINE CLAIMS WILL ONLY BE ALLOWED AT THE LOWEST VALUE LEVEL AND YOU WILL LIKELY RECEIVE NO RECOVERY.

### **Section 4.A: Qualifying Cancers**

Please select one or more of the following diagnoses received after prescription or use of an Eligible Debtor Product that is attributed to your continued use of an Eligible Debtor Product. Attribution of a condition to a complication from prescription of Ranitidine and/or the use thereof may be established by a temporal relationship between the prescription or use of Ranitidine, the frequency of use of the Ranitidine and the Qualifying Cancer. *Include evidence of the following diagnoses as well as any evidence that these diagnoses are attributable to your prescription of the Eligible Debtor Product when submitting this Ranitidine Trust Submission Form. For the avoidance of doubt, you are required to attach medical records to this form to establish that you were diagnosed with a Qualifying Cancer in order to potentially receive a recovery on account of your claims pursuant to the Ranitidine Claims Process. All such medical records must be provided by the August 5, 2024 deadline in order to be considered by the Ranitidine Trust.*

Please mark all that are applicable to your claim.

- Liver Cancer
- Gastrointestinal/Stomach Cancer
- Bladder Cancer
- Pancreatic Cancer
- Esophageal Cancer

### **Section 4.B: Additional Considerations**

Please select any of the following additional considerations. *Include evidence of the following additional considerations when submitting this Ranitidine Trust Submission Form.*

Please mark all that are applicable to your claim.

- Claimant was less than 89 years of age when diagnosed with a Qualifying Cancer
- Death as a result of a Qualifying Cancer

## **PART FIVE: MEDICAL LIENS**

**Section 6:** Did any insurance company pay for medical treatment for the Ranitidine-related injuries that gave rise to your Ranitidine Claim?

- Yes
- No

**PART SIX: SIGNATURE**

This Ranitidine Trust Submission Form must be signed by the Ranitidine Claimant or the Ranitidine Claimant's Representative.

Name of person signing this Ranitidine Trust Submission Form: \_\_\_\_\_

E-mail address of person signing this Ranitidine Trust Submission Form: \_\_\_\_\_

Phone Number of Person signing this Ranitidine Trust Submission Form: \_\_\_\_\_

I am including the evidence requested above in my submission of this Ranitidine Trust Submission Form:

*I declare under penalty of perjury that the representations made and the information provided on this Ranitidine Trust Submission Form are true, correct and complete to the best of my knowledge.*

\_\_\_\_\_  
*Signature of Ranitidine Claimant (or signature of Representative Completing this Ranitidine Trust Submission Form on Behalf of a Ranitidine Claimant)*

**Exhibit 3**

**HIPAA Release Form**

**HIPAA RELEASE FORM FOR RANITIDINE CLAIMS**  
**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

**Claimant Name:**

**Date:**

**Date of Birth:**

**Soc. Sec. No.**

1. The following individuals or organizations are authorized to disclose my protected health and insurance records to the parties specified below in section #4:

Note: Please list the names of your medical care providers and your health insurance providers that may have records relevant to the resolution of your Ranitidine Claim.<sup>4</sup> If you are unsure of the exact legal name of your medical providers and health insurance providers, you can leave this blank, and we will complete it for you with the understanding that you authorize all relevant parties:

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2. The type and amount of information to be used or discloses is as follows:

The entire protected medical and insurance record, including but not limited to: any and all medical records, mental health records, psychological records, psychiatric records, problem lists, medication lists, lists of allergies, immunization records, history and physicals, discharge summaries, laboratory results, x-ray and imaging reports, medical images of any kind, video tapes, photographs, consultation reports, correspondence, itemized invoices and billing information, and information pertaining to Medicaid or Medicare eligibility and all payments made by those agencies, for the following dates:

Note: List the date range for which the medical providers and insurance companies above may have records relevant to the resolution of your Ranitidine Claim. If you are unsure of the exact dates, then leave this blank, and we will complete this section for you with the understanding that you authorize all relevant date ranges.

Dates of Services - From: \_\_\_\_\_ To: \_\_\_\_\_

<sup>4</sup> Capitalized terms used but not defined herein shall have the meanings ascribed to them in the Ranitidine Trust Agreement, the Plan, the Confirmation Order, or the GUC Trust Documents.

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, as well as treatment for alcohol and drug abuse.
4. The health and insurance information may be disclosed to and used by the following individual and/or organization:
  - a. Ranitidine Trust;
  - b. Heather Barlow, as the Trustee and Claims Administrator of the Ranitidine Trust;
  - c. Any professionals engaged by the Ranitidine Trust to perform such tasks;
  - d. Matthew Dundon, as the Trustee of the GUC Trust, and any professionals engaged by the GUC Trust to perform such tasks;
  - e. The Debtors' insurers that provide coverage for Ranitidine Claims; and
  - f. In connection with any lien resolution program.
5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Ranitidine Trust. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 10 years after the date that I sign it.
6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and forego a recovery under the Ranitidine Trust Agreement. I understand that no organization may condition treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1634.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules or HIPAA. If I have questions about disclosure of my health information, I can contact the Ranitidine Trustee.

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Patient or Legal Representative

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Date

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Relationship to Patient (If signed by Legal Representative)



**Exhibit 4**  
**Heirship Declaration**

**HEIRSHIP DECLARATION FOR  
ENDO RANITIDINE SUB-TRUST DISTRIBUTION PROCEDURES**

**SWORN DECLARATION AND RELEASE**

Any heir (the “**Heir**”) of a holder of a Ranitidine Claim, where the Ranitidine Claimant has died before the Ranitidine Claim is paid (the “**Decedent**”), is required to complete this declaration if the Heir has not been named as the executor/administrator of the Decedent’s estate by a probate court. Moreover, the Heir must also provide notice to any other beneficiary who may be entitled to receive a portion of any distribution from the Endo Ranitidine Trust (the “**Ranitidine Trust**”) to ensure that all potential beneficiaries have received fair and proper notice of this distribution.

**I. Decedent Information**

Name:	First Name	Middle Initial	Last Name
Social Security Number:	Date of Death:		
Residence/Legal Domicile Address at Time of Death	Street		
	City	State	Zip Code

**II. Heir Information**

Your Name	First Name	Middle Initial	Last Name
Your Social Security Number			
Your Address	Street		
	City	State	Zip Code
Your Relationship to Decedent			

**III. Authority to Receive a Distribution**

I, \_\_\_\_\_, an Heir, have authority to act on behalf of Decedent for one of the following reasons (please select *one* and provide the applicable documentation):

_____	<b>Decedent Executed a Valid Will Naming the Heir as the Executor/Administrator</b>	
	List here and attach copies of all document(s) evidencing a valid Last Will and Testament executed by Decedent naming the Heir as Executor/Administrator:	1. Last Will and Testament of _____, dated _____. 2. _____ 3. _____

### III. Authority to Receive a Distribution (continued)

____	<b>Decedent Executed a Valid Testamentary Trust Naming Heir as the Trustee</b>	
List here and attach copies of all document(s) evidencing a valid Testamentary Trust executed by Decedent naming the Heir as Trustee:	1. Testamentary Trust executed by _____, dated _____. 2. _____ 3. _____	
____	<b>Decedent Did Not Execute a Valid Testamentary Document (did not have an executed Will or Trust)</b>	
List here the intestate statute(s) of the Residence/Legal Domicile at Time of Death of the Decedent and attach a copy of the full language of the statute(s):	1. A copy of the intestate statute(s) of the state or domicile of the Deceased Claimant at the time of his or her death. 2. _____ 3. _____	

### IV. Notice to Heirs and Beneficiaries of Decedent

(Attach additional sheets if needed)

Use the space below to identify the name and address of all persons who may have a legal right to share in any payment on behalf of the claim of the Decedent. Also state if and how you notified these persons of the Ranitidine Trust, or the reason they cannot be notified.

	Name:	Information:	
1.		Address	
		Relationship to Decedent	
		Notified of Ranitidine Trust?	___ Yes. How notified: _____ ___ No. Why not notified: _____ _____
2.		Address	
		Relationship to Decedent	
		Notified of Ranitidine Trust?	___ Yes. How notified: _____ ___ No. Why not notified: _____ _____

IV. Notice to Heirs and Beneficiaries of Decedent (continued)			
	Name:	Information:	
3.		Address	
		Relationship to Decedent	
		Notified of Ranitidine Trust?	<input type="checkbox"/> Yes. How notified: _____ <input type="checkbox"/> No. Why not notified: _____ _____
4.		Address	
		Relationship to Decedent	
		Notified of Ranitidine Trust?	<input type="checkbox"/> Yes. How notified: _____ <input type="checkbox"/> No. Why not notified: _____ _____
5.		Address	
		Relationship to Decedent	
		Notified of Ranitidine Trust?	<input type="checkbox"/> Yes. How notified: _____ <input type="checkbox"/> No. Why not notified: _____ _____
6.		Address	
		Relationship to Decedent	
		Notified of Ranitidine Trust?	<input type="checkbox"/> Yes. How notified: _____ <input type="checkbox"/> No. Why not notified: _____ _____
7.		Address	
		Relationship to Decedent	

		Notified of Ranitidine Trust?	___ Yes. How notified: _____ ___ No. Why not notified: _____ _____
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**V. Heir Certification – Sworn Declaration**

This Sworn Declaration is an official document for submission to the Ranitidine Trust. By signing this Sworn Declaration, I certify and declare under penalty of perjury pursuant to 28 U.S.C. §1746 that:

- A. I am seeking authority to act on behalf of the Decedent and his or her estate, heirs, and beneficiaries in connection with the Ranitidine Trust Agreement, including with respect to the submission of forms and supporting evidence and the receipt of payment for any such awards.
  
- B. I will abide by all substantive laws of the Decedent’s last state of domicile concerning the compromise and distribution of any monetary award to the appropriate heirs or other beneficiaries and any other parties with any right to receive any portion of any payments.
  
- C. If Decedent executed a valid Will naming the Heir as the Executor/Administrator:
  - a. No one else has been appointed the personal representative, executor, administrator, or other position with the authority to act on behalf of the Decedent and his or her estate.
  - b. The copy of the Last Will and Testament provided by me is the Last Will and Testament of the Decedent.
  - c. I will notify the Ranitidine Trust immediately if my authority to act is curtailed, surrendered, withdrawn, or terminated.
  
- D. If Decedent executed a valid Testamentary Trust naming the Heir as the trustee:
  - a. No one else has been appointed the personal representative, executor, administrator, or other position with the authority to act on behalf of the Decedent and his or her estate.
  - b. No one else has been appointed the trustee or other position with the authority to act on behalf of the Decedent and his or her estate.
  - c. The copy of the Testamentary Trust provided by me is the currently valid Testamentary Trust of the Decedent.
  - d. I will notify the Ranitidine Trust immediately if my authority to act is curtailed, surrendered, withdrawn, or terminated.
  
- E. If the Decedent did not execute a valid testamentary document:
  - a. No one else has been appointed the personal representative, executor, administrator, or other position with the authority to act on behalf of the Decedent and his or her estate.
  - b. There is no known Last Will and Testament of the Decedent and no application or proceeding has been filed in state or other court to administer the estate of the Decedent or to appoint an executor or administrator.
  - c. I will notify the Ranitidine Trust immediately if my authority to act is curtailed, surrendered, withdrawn, or terminated.
  
- F. No application or proceeding has been filed in state or other court to administer the estate of the Decedent or to appoint an executor or administrator of the Decedent’s estate.
  
- G. I am not aware of any objections to my appointment and service as the Heir on behalf of the Decedent and his or her estate, heirs, and beneficiaries.

H. No person notified under Section IV objects to my serving as the Heir and taking such steps as required by the Ranitidine Trust Agreement to resolve all claims related to the Decedent's prescription and/or use of Ranitidine. The persons named in Section IV are all of the persons who may have a legal right to share in any payment issued in respect of the injuries of the Decedent.

**V. Heir Certification – Sworn Declaration (Continued)**

I. I will comply with any and all provisions of the state law regarding the compromise and distribution of the proceeds of any payment from the Ranitidine Trust to the appropriate heirs or other beneficiaries and any other parties with any right to receive any portion of any payments.

J. In accordance with item I. above, I understand that I am responsible for locating and paying all heirs their proportionate share of any distribution based on the applicable Will, Trust or Intestate Statute.

K. I will indemnify, defend and hold harmless the Ranitidine Trust, its agents and representatives, and any law firm(s) representing me from any and all claims, demands, or expenses of any kind arising out of distributions from the Ranitidine Trust.

L. I understand that, by signing this Sworn Declaration, the sole remedy for any beneficiary that contests the allocation of the distribution from this case is to pursue me directly.

The information I have provided in this Declaration is true and correct. I understand that the Ranitidine Trust, the Bankruptcy Court for the Southern District of New York and any law firm(s) representing me will rely on this Declaration, and false statements or claims made in connection with this Declaration may result in fines, imprisonment, and/or any other remedy available by law.

I, the undersigned, declare the above as true and correct under penalty of perjury:

Signature:		Date:	
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