Attorney Name:

Contact Name

Submit completed claims to:

Kaiser Aluminum & Chemical Corporation Silica PI Trust
c/o Verus Claims Services, LLC
3967 Princeton Pike, Princeton, NJ 08540
trustsupport@verusllc.com
www.kaisersilicatrust.com

KAISER ALUMINUM & CHEMICAL CORPORATION SILICA PI TRUST CLAIM FORM

Instructions for the Claim Form

Complete this Claim Form as thoroughly and accurately as possible. Please type or print neatly. Should there be insufficient space to list all relevant information for any item, please attach additional sheets (*include Claimant's name and Social Security number at the top of each additional sheet submitted*). Please check the box and submit each of the following with this Claim Form that is applicable to this claim:

- ☐ Diagnosis of silica-related disease and required Medical Records
- ☐ Proof of Industry Exposure (credible third-party evidence such as social security records—see the Silica Distribution Procedures for details)
- ☐ Supporting materials for claims seeking Individual Review for enhanced claim valuation (Type 2 Claims)
- ☐ Death Certificate (if applicable)
- ☐ Letters Testamentary or estate documentation pursuant to applicable law or Certificate of Official Capacity (if Claimant Representative is filing form) or Attorney Certification and Warranty of Claimant Representative's Authority executed below
- ☐ Filing Fee (waived for claims for which a timely proof of claim was filed in the Kaiser Aluminum and Chemical Corporation bankruptcy case)

Representation by Counsel

If Claimant or Claimant Representative is represented by counsel, please provide the Law Firm Code and Attorney/Contact Code above. If the Law Firm has not registered with the Trust, please contact the Trust to register at the address for submission of claims above.

Part 1: Type of Claim

Please choose the applicable type of claim (choose only one):

☐ Type 1 (Expedited Review) Claim

☐ Type 2 (Individual Review) Claim

NOTE: All claims will be considered for the type of claim category that is supported by the evidence submitted, regardless of which blank is checked.

Part 2: Injured Party/Claimant Information

NOTE: As used in this Claim Form, the "Claimant" is the person filing the Claim Form directly or through a licensed attorney. The Claimant may be the "Injured Party" who is the person with a silica-related disease from occupational or secondary exposure, or a "Claimant Representative" who is the representative of the Injured Party or the Injured Party's estate or heirs.

A Injured Party's Full Name:_____

Street Address:_____City:_____

State:_____Country:_____Zip:_____

SSN:_____ Daytime Phone: (____)_____

Date of Birth:____/____/_____ If deceased, Date of Death___/_____/_____

B. If the Claim is being filed by a Claimant Representative, other than the licensed attorney submitting this claim form, provide the following for the Claimant Representative:

1. Full Name:_____

Street Address:_____City:_____

State:_____Country:_____Zip:_____

Daytime Phone: (_____)_____

2. Claimant Representative's Capacity (***choose one***):

☐ Executor / Administrator / Trustee ☐ Guardian

☐ Attorney-In-Fact ☐ Other (specify):_____

Part 3: Diagnosed Silica-Related Injuries

Indicate the highest level (most serious) silica-related disease that has been diagnosed for the Injured Party and for which medical documentation is submitted with this Claim Form.

Disease Level	**Disease Description**	**Date of Diagnosis** mm/dd/yyyy
I	Mixed Dust Fibrosis (Foundry Workers' Lung Disease)	___/___/_____
II	Simple Silicosis	___/___/_____
III	Severe Silicosis	___/___/_____
IV	Lung Cancer	___/___/_____
V	Complicated Silicosis	___/___/_____

The claim must meet the relevant criteria and be supported by appropriate documentation and credible evidence as described in the Silica Distribution Procedures. **All claims will be considered for the highest disease category that is supported by the evidence submitted, regardless of which disease is checked.** A summary of the presumptive Medical Criteria for the five Disease Levels set forth above is set forth in the Instructions to this Claim Form, but in the event of any inconsistency between such summary and the provisions of the Silica Distribution Procedures, the provisions of the Silica Distribution Procedures shall control.

Part 4: Litigation

Has a lawsuit ever been filed by or on behalf of the Injured Party or the Claimant against any party claiming an injury related to the Injured Party's exposure to silica-containing materials?

☐ Yes ☐ No

Provide the following information for each such lawsuit. If more space is needed, please photocopy this page, and insert after current page (*include Claimant name and Social Security number at the top of each additional sheet submitted*).

1. Two-letter abbreviation of the state in which the suit was originally filed: [___]

   Plaintiff(s) name: _____

   Case (or Docket) Number: _____

   Date on which the suit was originally filed: _____

   Status of suit: _____

2. Two-letter abbreviation of the state in which the suit was originally filed: [___]

   Plaintiff(s) name: _____

   Case (or Docket) Number: _____

   Date on which the suit was originally filed: _____

   Status of suit: _____

3. Two-letter abbreviation of the state in which the suit was originally filed: [___]

   Plaintiff(s) name: _____

   Case (or Docket) Number: _____

   Date on which the suit was originally filed: _____

   Status of suit: _____

4. Two-letter abbreviation of the state in which the suit was originally filed: [___]

   Plaintiff(s) name: _____

   Case (or Docket) Number: _____

   Date on which the suit was originally filed: _____

   Status of suit: _____

Part 5: Industry Exposure and Occupational Exposure

Proof of Industry Exposure must be provided for all claims as required by the Silica Distribution Procedures. In addition, proof of Occupational Exposure must be submitted as support for enhanced claim valuation for Type 2 (Individual Review) Claims. If the Injured Party claims secondary exposure (see Part 6), proof of Industry Exposure (for Type 1 and Type 2 Claims) must be provided for the occupationally exposed person ("OEP") who is the basis for the secondary exposure claim, and proof of Occupational Exposure for the OEP who is the basis for the secondary exposure claim must be submitted for a Type 2 Claim.

Was the Injured Party an employee of Kaiser Aluminum and Chemical Corporation, Kaiser Refractories, Kaiser Engineers, Kaiser Metal Products, Henry J. Kaiser, Mexico Refractories Company, Permanente Metals Corporation or Denver Fire Clay Company?

☐ Yes ☐ No

A. If so, during what years? (yyyy) ____ to (yyyy) ____

B. Industry and Occupational Exposure: Complete for each claimed Industry Exposure. If more space is needed, please photocopy this page, and insert after current page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Exposure B1:

1. Name of Plant /Site of Exposure: _____
_____

City: _____ State: _____

2. Month/Year Exposure Began: (mm/yyyy) ___/____
Month/Year Exposure Ended: (mm/yyyy) ___/____

3. Name(s) of Employer(s) at time of Exposure:_____
_____
_____

4. For Type 1 and Type 2 Claims—Industry in which exposure occurred: _____ (See Industry Codes table below—if Industry in which the Exposure occurred is not listed below, complete Part 5, Section C below for each such claimed Exposure.)

5. For Type 2 Claims—Occupation at time of Exposure _____(See Occupation Codes Table below—if the Occupation in which Exposure occurred is not listed below, complete Part 5, Section D below). If exposure is claimed in more than one Occupation in an Industry, please

complete an Exposure table for each Occupation. If necessary, photocopy this page, complete for each Occupation and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Exposure B2:

1. Name of Plant /Site of Exposure: _____
_____

   City: _____ State: _____

2. Month/Year Exposure Began: (mm/yyyy) ___/____
   Month/Year Exposure Ended: (mm/yyyy) ___/____

3. Name(s) of Employer(s) at time of Exposure:_____
_____
_____

4. For Type 1 and Type 2 Claims—Industry in which exposure occurred: _____ (See Industry Codes table below—if Industry in which the Exposure occurred is not listed below, complete Part 5, Section C below for each such claimed Exposure.)

5. For Type 2 Claims—Occupation at time of Exposure _____(See Occupation Codes Table below—if the Occupation in which Exposure occurred is not listed below, complete Part 5, Section D below). If exposure is claimed in more than one Occupation in an Industry, please complete an Exposure table for each Occupation. If necessary, photocopy this page, complete for each Occupation and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Exposure B3:

1. Name of Plant /Site of Exposure: _____
_____

City: _____ State: _____

2. Month/Year Exposure Began: (mm/yyyy) ___/____
Month/Year Exposure Ended: (mm/yyyy) ___/____

3. Name(s) of Employer(s) at time of Exposure:_____
_____
_____

4. For Type 1 and Type 2 Claims—Industry in which exposure occurred: _____ (See Industry Codes table below—if Industry in which the Exposure occurred is not listed below, complete Part 5, Section C below for each such claimed Exposure.)

5. For Type 2 Claims—Occupation at time of Exposure _____(See Occupation Codes Table below—if the Occupation in which Exposure occurred is not listed below, complete Part 5, Section D below). If exposure is claimed in more than one Occupation in an Industry, please complete an Exposure table for each Occupation. If necessary, photocopy this page, complete for each Occupation and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Exposure B4:

1. Name of Plant /Site of Exposure: _____
_____

City: _____ State: _____

2. Month/Year Exposure Began: (mm/yyyy) ___/____
Month/Year Exposure Ended: (mm/yyyy) ___/____

3. Name(s) of Employer(s) at time of Exposure:_____
_____
_____

4. For Type 1 and Type 2 Claims—Industry in which exposure occurred: _____ (See Industry Codes table below—if Industry in which the Exposure occurred is not listed below, complete Part 5, Section C below for each such claimed Exposure.)

5. For Type 2 Claims—Occupation at time of Exposure _____(See Occupation Codes Table below—if the Occupation in which Exposure occurred is not listed below, complete Part 5, Section D below). If exposure is claimed in more than one Occupation in an Industry, please complete an Exposure table for each Occupation. If necessary, photocopy this page, complete for each Occupation and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Industry Codes Table

A.	Primary Steel and Iron Manufacturing
B.	Aluminum Manufacturing
C.	Cement Plants
D.	Ferrous and Non-Ferrous Foundries
E.	Furnace Manufacturers and Contractors
F.	Glass and Ceramics Plants
G.	Copper Smelting

Occupation Codes Table

1. Brickmasons (including bricklayers and brickhackers)	8. Pourers
2. Refractory materials repairers and helpers (construction and maintenance of ladles, furnaces & kilns)	9. Ladle liners
3. Furnace tenders	10. Pattern makers
4. Millwrights	11. Equipment operators (transport of refractory products)
5. Boiler room workers (operators and maintenance)	12. Material handlers (refractory products)
6. Molders and Casters	13. Laborers, general maintenance and custodial staff working in proximity of refractory products
7. Coremakers	14. Supervisors of any of the above
	15. Sandblasters
	16. Laborers, general maintenance and custodial staff working in proximity to sandblasting operations

C. Alternate Industry Exposure. If the Injured Party did not have a minimum of six months of cumulative exposure in one of the industries for which an Industry Code is listed above for any of the claimed Exposures, provide for each of those Exposures the following information and credible evidence of six months or greater cumulative exposure to respirable silica as a result of handling, installing, using, repairing, tearing out or cleaning out silica-containing refractory products manufactured or distributed by Kaiser or working on a regular basis in close proximity to workers engaged in such activities. Provide the following information for each job site that the Injured Party is relying upon in order to establish such exposure: If more space is needed, please photocopy this page, complete for each such Exposure (with the corresponding Exposure number) and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Exposure B__ (enter corresponding Exposure number from Part 5, Section B)

a. Job Site: _____

b. City/State: _____

c. Industry: _____

d. Name(s) of Kaiser silica-containing refractory product(s) to which exposure is claimed: _____
_____
_____
_____

Exposure B__ (enter corresponding Exposure number from Part 5, Section B)

a. Job Site: _____

b. City/State: _____

c. Industry: _____

d. Name(s) of Kaiser silica-containing refractory product(s) to which exposure is claimed: _____
_____
_____
_____

D. Alternate Occupational Exposure. If any claimed Exposure above is not completed with an Occupation Code because the Occupation in which the Exposure occurred is not listed, provide the following information to identify the name, nature and duties of each Occupation in which such Exposure occurred as follows: If more space is needed, please photocopy this page, complete for each such Exposure (with the corresponding Exposure number) and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*). Note: Occupational Exposure is not required for a Type 1 claim but must be submitted as a factor for consideration in valuing a Type 2 Claim.

Exposure B__ (enter corresponding Exposure number from Part 5, Section B)

a. Name of Occupation: _____

b. Nature of Occupation and Duties: _____
_____
_____

c. Select one or more:

i. ____ Handled, installed, used, repaired, tore out or cleaned out silica-containing refractory products manufactured or distributed by Kaiser; or

ii. ____ Worked on a regular basis in close proximity to workers who did one or more of the above activities; or

iii. ___Other (please describe in detail): _____
_____
_____
_____
_____
_____
_____

Exposure B__ (enter corresponding Exposure number from Part 5, Section B)

a. Name of Occupation: _____

b. Nature of Occupation and Duties: _____
_____
_____

c. Select one or more:

i. ____ Handled, installed, used, repaired, tore out or cleaned out silica-containing refractory products manufactured or distributed by Kaiser; or

ii. ____ Worked on a regular basis in close proximity to workers who did one or more of the above activities; or

iii. ___Other (please describe in detail): _____
_____
_____
_____
_____
_____
_____

Part 6: Exposure to an Occupationally Exposed Person

Is the Injured Party alleging a silica-related disease resulting in whole or in part from another person's occupational exposure, such as a family member (spouse, father, sister, etc.)?

☐ Yes ☐ No

If yes, complete the following and Part 5 for each OEP.

OEP's Full Name:_____

SSN:_____

Date Exposure to OEP began: (mm/yyyy) ___/____

Date Exposure to OEP ended: (mm/yyyy) ___/____

Describe how the Injured Party was exposed to Kaiser silica-containing refractory product(s) through the OEP (Example – Injured Party washed the OEP's work clothes on a regular basis for a period of 5 years):

_____

_____

_____

_____

_____

_____

_____

_____

Reminder: Part 5 <u>must</u> be completed for the OEP.

Part 7: Smoking History

NOTE: This information is relevant only to Type 2 (Individual Review) Claims. This section is not required to be completed if your claim is for a Type 1 (Expedited Review) Claim.

For each item, indicate whether the Injured Party smoked tobacco products. If the Injured Party stopped smoking prior to death, enter the last date the Injured Party smoked.

Has the Injured Party ever:

Smoked? ☐ Yes ☐ No

If "Yes" is checked and the Injured Party stopped smoking prior to death, enter the last date the Injured Party smoked: (mm/yyyy) ___/____

Part 8: Individual Review Factors

NOTE: This section is optional and is only required to be completed if you want this information to be considered in connection with enhanced claim valuation for a Type 2 (Individual Review) Claim. Proof of Occupational Exposure under Part 5 must also be provided for consideration in connection with enhanced claim valuation for a Type 2 Claim.

A. Describe any unusual or extraordinary financial loss, including lost wages or medical expenses that you assert should entitle you to receive more than the Scheduled Value for the highest disease category for which your claim qualifies: The Trust's valuation process automatically calculates and considers lost wages to age 65, but the Claimant can submit more specific information by completing an Expense Worksheet which is available on request from the Trust to use in submitting information on medical expenses and lost wages as economic loss.

B. The Injured Party has a total of ________________dependents. Provide the information below for each dependent. Be sure to include the Injured Party's spouse and/or any dependents who derive (or who did derive at the time of the Injured Party's death) at least one-half of their financial support from the Injured Party. Also list beneficiaries represented by Injured Party's counsel who are entitled to pursue an action for wrongful death under applicable state law. If more than four, please photocopy this page, and insert the copies after this page (*include Claimant's name and Social Security number at the top of each additional sheet submitted*).

Name:____
Social Security Number:____
Date of Birth: (mm/dd/yyyy) ___/___/____
Relationship: _____Spouse Financially Dependent? Yes / No
_____Child (Circle One)
_____Other__________________

Name:____
Social Security Number:____
Date of Birth: (mm/dd/yyyy) ___/___/____
Relationship: _____Spouse Financially Dependent? Yes / No
_____Child (Circle One)
_____Other__________________

Name:____
Social Security Number:____
Date of Birth: (mm/dd/yyyy) ___/___/____
Relationship: _____Spouse Financially Dependent? Yes / No
_____Child (Circle One)
_____Other__________________

Name:____
Social Security Number:____
Date of Birth: (mm/dd/yyyy) ___/___/____
Relationship: _____Spouse Financially Dependent? Yes / No
_____Child (Circle One)
_____Other__________________

C. Describe any claimed special damages attributable to the claimed silica-related disease: ____
____

D. Describe any claimed extraordinary impairment attributable to the claimed silica-related disease: ____
____

Part 9: Signature Page

All claims must be signed by the Claimant, or the person filing on his/her behalf (such as the Claimant Representative or attorney).

If signed below by the Claimant or the Claimant Representative, the undersigned certifies, under penalty of perjury, as follows: 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 the information submitted is accurate and complete.

If signed below by the attorney for the Claimant or the Claimant Representative, the undersigned certifies, under penalty of perjury, as follows: I am authorized to file this Claim Form; I, or other trained personnel within my firm, have reviewed the information submitted on this Claim Form and all documents submitted in support of this claim; and to the best of my knowledge, based on policies and procedures adopted and implemented by my firm concerning claims processing, the information submitted is true, accurate and complete, and/or the information is included within the Claimant's file and is derived from information provided by the Injured Party, one or more of the Injured Party's co-workers or the Injured Party's medical experts.

I consent to the furnishing of the name and social security number of the Claimant and the Injured Party and the name of the attorney (if any) representing the Claimant and the Injured Party and all claims materials and supporting evidence and documentation to the Kaiser Aluminum and Chemical Corporation Asbestos PI Trust, the Kaiser Aluminum and Chemical Corporation CTPV (Coal Tar Pitch Volatiles) PI Trust and the Kaiser Aluminum and Chemical Corporation NIHL (Noise Induced Hearing Loss) PI Trust pursuant to, and subject to the conditions set forth in, Section 2.2(c) of the Silica Distribution Procedures.

_____

Signature of Claimant, Claimant Representative or attorney

_____

Please print the name and relationship to the Claimant of the signatory above.

Attorney Certification and Warranty of Claimant Representative's Authority

This section must be executed by the Attorney only if (i) the Injured Party has a Claimant Representative and (ii) neither Letters Testamentary or estate documentation pursuant to applicable law nor a Certificate of Official Capacity is submitted with this claim form. The Attorney certifies and warrants that this claim is filed on behalf of the Injured Party by the Claimant Representative and that the Claimant Representative is authorized by law to file this claim on behalf of the Injured Party.

_____

Signature of Attorney/Name of Firm