CV001	**CONSUMER VIOXX SETTLEMENT CLAIM FORM** **SUBMIT BY MAY 6, 2014**

INSTRUCTIONS

If you wish to submit a claim for a Settlement payment, you need to provide the information requested below. More information is available at the official Settlement website, www.VioxxSettlement.com, or call 1-866-439-6932. Please print clearly in blue or black ink. You will need to submit a Claim Form and any required documents by **May 6, 2014** to get benefits. You can submit a Claim Form online or by mail.

1. CLASS MEMBER INFORMATION

Name	Last	First	Middle	
Address	Street/P.O. Box			
	City	State	Zip	
Telephone Number	(_____) _____-_____	**Email**		
Date of Birth	_____/_____/_____ (Month/Day/Year)	**SSN***	_____ - ____ - _____	

Are you making a claim as a parent or guardian of another person? **YES** ☐ **NO** ☐

Attorney Information	If you have your own attorney for this claim, provide the attorney's name and contact information:

2. PRESCRIBER INFORMATION

Name and address of the doctor, hospital, medical facility, or pharmacy that prescribed or sold Vioxx to you:

Physician Name	Last	First	Middle	
Hospital/Medical Facility or Pharmacy Name	Hospital/Medical Facility or Pharmacy Name			
Address	Street			
	City	State	Zip	Country

* Your Social Security Number and the other personally identifiable information you provide are subject to court protection.

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3. CLAIM PAYMENT OPTIONS

Choose one of the two claim payment options below and check the boxes to indicate the proof of purchase documentation you will submit. For Option 1, you can submit a claim for out-of-pocket costs and Post-Withdrawal Medical Consultation. Option 2 provides a $50 payment. You must submit the required documentation with this form for your claim to be valid.

☐ **Option 1**

Option 1a - Reimbursement of Out-of-Pocket Prescription Costs for Vioxx (Vioxx Proof of Payment). To make a claim under Option 1, you must provide **one** of the following forms of proof showing you were prescribed Vioxx and that you paid out-of-pocket for your prescriptions. Check the form(s) of proof you are submitting:

☐ **Receipt of Payment**	I am submitting receipt(s), cancelled check(s), or credit card statement(s) showing I paid out-of-pocket for Vioxx for my personal or family use for which I was not reimbursed.
☐ **Insurer EOB**	I am submitting an explanation of benefits from my insurer, Medicare, or Medicaid that shows Vioxx was prescribed and the amount of co-payments I paid.
☐ **Pharmacy Record**	I am submitting records from my pharmacy, PBM (pharmacy benefit manager), or similar entity showing I was prescribed Vioxx and the amount of my unreimbursed out-of-pocket costs in buying Vioxx.

Option 1b - Post-Withdrawal Medical Consultation

If, as part of an Option 1a Claim, you also want to be reimbursed up to $75 in total for costs or losses for any and all Post-Withdrawal Medical Consultations, you must attach: (1) proof of the medical consultation, (2) proof of the amount of the cost or loss claimed (that was out-of-pocket and not reimbursed), and (3) a statement that the medical consultation or diagnostic testing occurring between September 30, 2004 and November 30, 2004 had not been scheduled or recommended before September 30, 2004. If the physician for the Post-Withdrawal Medical Consultation was different than the prescriber listed above, provide the name and address of the physician:

Last	First	Middle

Street/P.O. Box

City	State	Zip

TOTAL AMOUNT CLAIMED

The total amount of out-of-pocket costs and losses that I am claiming under Option 1a is: $_____.

The total amount of out-of-pocket costs and losses that I am claiming under Option 1b is:_____. The recovery for Option 1b cannot be greater than $75 regardless of the costs or losses.

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NOTE: If you are making a claim for over $600, you will be sent an IRS W-9 Form. You must complete and return this form to the Claims Administrator before your claim can be paid.

☐ **Option 2 – One Time Payment of up to $50 (With Alternative Proof of Prescription of Vioxx)**

To make a claim under Option 2, you must provide **one** of the following forms of proof showing you were prescribed Vioxx. Check the form(s) of proof you are submitting:

☐ **Medical Record**	I am submitting a medical record showing that I was prescribed Vioxx by the health care provider listed in Section 2.
☐ **Doctor's Letter**	I am submitting a letter from my doctor, listed in Section 2, saying that he or she prescribed Vioxx to me and the approximate dates of my prescribed usage.
☐ **Prescription Bottle**	I am submitting an empty prescription bottle and label showing that I filled a prescription of Vioxx that was prescribed to me by the doctor listed in Section 2.
☐ **Sworn Statement**	By checking this box and signing this Claim Form, I am declaring that I purchased Vioxx using personal or family funds and that the other forms of proof of payment or proof of prescription are not available.

4. SIGN AND DATE YOUR CLAIM FORM

I declare under penalty of perjury that the information in this Claim Form and attached documentation are true and correct to the best of my knowledge.

Signature			**Date**	_____/_____/_____ (month) (day) (year)
Printed Name	First	MI	Last	

Claims may be audited and any false or fraudulent claim is subject to prosecution.

5. MAIL YOUR CLAIM FORM

This Claim Form and all supporting documents must be submitted online, or postmarked and mailed, by **May 6, 2014**. You can submit your Claim Form at www.VioxxSettlement.com or mail it to:

Vioxx Consumer Claims Administrator
P.O. Box 26882
Richmond, VA 23261

Remember to include all required documentation