Shook & Fletcher
Asbestos Settlement Trust

Proof of Claim Form

Send Claims to:

Shook & Fletcher Asbestos Settlement Trust
c/o MFR Claims Processing, Inc.
115 Pheasant Run
Suite 112
Newtown, PA, 18940
(215) 702-8033

Instructions for the Claim Form

Complete this claim form as thoroughly and accurately as possible. Please note that this claim form will not be accepted or processed unless the certification is executed in Section G below. Please type or print neatly. Should there be insufficient space to list all relevant information, please attach additional sheets. In addition to filing the forms that follow, please ensure the following are enclosed, if applicable:

- Death Certificate (if applicable)
- Certificate of Official Capacity (if personal representative is filing form)
- Medical records as requested in instructions

By completing this form, the claimant agrees to provide such supporting documentation as may be requested by the Trust in respect of such claimant's claim.

Plaintiff Law Firm Contact Information

Firm Name _____

Atty Name_____ Phone _____

Para/Admin Name_____ Phone _____

Address _____

_____

Email _____

Fax _____

Section A **Special Claims Status**

(See Claims Resolution Procedures, SECTION V)

Extraordinary (Section 5.3(a)) _____

Exigent Hardship (Section 5.3(b)) _____
(Must also undergo Individual Review)

Derivative (Section5.4) _____

Individual Review (Section 5.2(f)) _____
(For Individual Review, submit $100.00 fee via check payable to the Shook & Fletcher Asbestos Settlement Trust)

Section B **Injured Party**

Name: _____ _____ _____
First Middle Last

Social Security Number: _____- _____- _____

Date of Birth: _____ _____ _____
Month Day Year

Address (If Living): _____
Street

_____ _____ _____
City State Zip

Section C **If Injured Party is Deceased**

Date of Death**:** _____

Personal Rep Info:

Name: _____ _____ _____
First Middle Last

Social Security Number: _____ - _____ - _____

Address: _____
Street

_____ _____ _____
City State Zip

Section D **Lawsuit against Shook & Fletcher Insulation Co. or any other Protected Party**[1]

Suit Filed? _____ _____
Yes No

If Yes:
Date Filed _____ _____ _____
Month Day Year

[1] "Protected Party" is defined in that certain Second Amended Glossary of the Terms for the Plan of Reorganization under Chapter 11 of the United States Bankruptcy Code for Shook & Fletcher Insulation Co. (the "Glossary") as "any of the following parties: (a) the Debtor, Reorganized Shook & Fletcher, Shook & Fletcher Supply, the Asbestos Claimants Committee, Claimants' Counsel, the Futures Representative, and the TAC, and any of their present, former and post-Confirmation Date Affiliates, officers, directors, shareholders, agents, employees, members, representatives, advisors, financial advisors, accountants and attorneys; (b) the Trust, and any of its trustees, officers, directors, agents, employees, representatives, advisors, financial advisors, accountants and attorneys; (c) the Pre-Petition Trust, and any of its trustees, officers, directors, agents, employees, representatives, advisors, financial advisors, accountants, and attorneys; (d) any Entity that, pursuant to the Plan or after the Confirmation Date, becomes a direct or indirect transferee of, or successor to, Reorganized Shook & Fletcher; and (e) each Settling Asbestos Insurance Company." Any capitalized but undefined term used in the preceding sentence is defined in the Glossary. Copies of the Glossary are available from the Trust upon written request.

State/Jurisdiction _____

Docket # _____

Suit Dismissed Against Protected Party?

_____ Yes _____ No

If Yes:

Date Dismissed _____ Month _____ Day _____ Year

If the suit has been dismissed, please submit proof of such dismissal with this Claim Form.

Section E **Asbestos Related Injury** **Date Of Diagnosis** (Month/Day/Year)

Disease Claimed:

Mesothelioma _____ _____

Lung Cancer _____ _____

Other Cancer _____ _____

Non Malignant _____ _____

Section F **Exposure**

All Exposure Claimed As to Shook and Fletcher

(Attach additional pages as necessary)

1) From _____ _____ To _____ _____
Month Year Month Year

Location of Exposure

_____
Jobsite

_____ _____
City State

_____
Occupation

_____
Employer

2) From _____ _____ To _____ _____
Month Year Month Year

Location of Exposure

_____
Jobsite

_____ _____
City State

_____
Occupation

_____
Employer

3) From _____ _____ To _____ _____
Month Year Month Year

Location of Exposure

_____
Jobsite

_____ _____
City State

_____
Occupation

_____
Employer

Section G. Certification. The following certification must be executed before this Proof of Claim will be accepted or processed.[2]

Attorney Certification

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 claimant, one or more of the claimant's co-workers or the claimant's medical experts.

By (signature): _____
Name (printed): _____
Firm: _____

[2] Note: If you are a claimant or personal representative filing this proof of claim form without an attorney, please contact MFR Claims Processing, Inc. using the contact information on the first page of this form or by email at shookinquiries@mfrclaims.com to request a claimant certification or personal representative certification, as applicable.