

copy of the Writ of Summons, Complaint or Short Form Complaint, as applicable, together with any and all attachments, shall be delivered by registered mail, return receipt requested upon the following:

For GSK Defendants:

GlaxoSmithKline
Ellen F. Hudock, Esq.
MC FP 2225
P.O. Box 7929
Philadelphia, PA 19101-7929

A copy of each Writ of Summons, Complaint or Short Form Complaint transmitted to any of the GSK Defendants in the foregoing manner also shall be served contemporaneously via email to Lead and Liaison Counsel for the GSK Defendants. General mailing to any of the GSK Defendants will not be sufficient to effect service. If addressed and served as described above (registered mail, return receipt requested to the designated representative indicated above and contemporaneous email service to Lead and Liaison Counsel for GSK and Plaintiffs), service will be considered effective ten (10) days after the date of actual receipt by the designated representative indicated above, as established by registered mail receipt. The foregoing procedure shall apply to Denture Adhesive Cream cases filed in this Court only and not to any other litigation. Defendants reserve all other rights available to them under federal or state law and under applicable treaties and conventions.

The GSK Defendants' responsive pleadings shall be due as set forth in the previously entered Case Management Order No. 1, the due date to be calculated from the effective date of service as described above.

B. Service of Process – P&G Defendants

The normal legal requirements for service of process shall apply to any of the P&G Defendants. The P&G Defendants' responsive pleadings shall be due as set forth in the previously entered Case Management Order No. 1 except that Case Management Order No. 1 is modified to require the P&G Defendants to file an Answer or Preliminary Objections to all Complaints and Short Form Complaints within twenty (20) days of the service of the same. The P&G Defendants

expressly reserve all rights under CMO No. 1 and the Pennsylvania Rules of Civil Procedure to file Preliminary Objections to Complaints or Short Form Complaints, and nothing in CMO No. 3 is intended to abrogate those rights. To the extent the P&G Defendants allege a new matter in any Answer to a complaint or short form complaint, Plaintiffs shall have twenty (20) days to respond or file a preliminary objection. If no responsive pleading is filed by Plaintiff, allegations in the new matter shall be deemed denied.

III. WRITTEN DISCOVERY

A. Plaintiff's Fact Sheets and Authorizations

1) Each Plaintiff who used denture cream and is claiming bodily injury as a result or the duly authorized representative of such a person shall complete and serve on Defendants' Liaison Counsel, a Plaintiff's Fact Sheet ("PFS") in the form of Attachment "A" hereto. Plaintiff's responses to the PFS shall be treated as answers to interrogatories under Rule 4006 and responses to request for production of documents under Rule 4009.12 and shall be supplemented in accordance with Rule 4007.4. Any limits on the number of Interrogatories do not apply to the PFS. The questions and requests for production contained in the PFS are non-objectionable and shall be answered without objection. This section does not prohibit a Plaintiff from withholding or redacting information based upon a recognized privilege. If a Plaintiff withholds or redacts any information on the basis of privilege, he or she shall provide Defendants with a privilege log pursuant to the below provisions. In the event that a dispute arises concerning the completeness or adequacy of a Plaintiff's response to any request or question contained in the PFS, this Section shall not prohibit the Plaintiff from asserting that his or her response is adequate.

2) Plaintiffs or their spouses who claim physical or emotional injuries shall provide Authorizations for Release of Records ("Authorizations") for Health Care Providers, Insurance Providers, Employment Records and Educational Providers in the form provided in Attachment "B" hereto (Health Care Provider Authorization, Insurance Provider Authorization, Employment

Authorization and Educational Provider Authorization). Plaintiffs or their spouses who claim physical injuries shall also provide Authorizations for workers compensation records in the form provided by the applicable jurisdiction (Attachment “C” contains a Pennsylvania-specific example) (Workers Compensation Authorization) to the extent Plaintiff has applied at any time for workers compensation benefits and Authorizations for social security disability records in the form provided in Attachment “D” hereto (Social Security Disability Authorization) to the extent Plaintiff has applied at any time for social security disability benefits.

3) Plaintiffs claiming past or future lost income or wages shall provide: Authorizations for release of Employers’ Payroll Records, including W2 records (if employed by an employer) in the form provided in Attachment “E”; and/or for release of tax records (only if self-employed) in the form provided in Attachment “F” hereto and for release of Social Security Earnings (Social Security Earnings Authorization in the form provided in Attachment “G” hereto.

4) Plaintiffs who identified mental health care provider(s) in response to the questions in Section 8.I. or Section 8.J of the PFS, shall provide Authorizations for the mental health care providers identified in response to those questions in the form provided in Attachment “H” hereto (Mental Health Care Provider Authorization).

5) Plaintiffs in cases that were filed before entry of this Order (“pre-October 16 Plaintiffs”) shall provide a completed and verified PFS, signed and dated Authorizations and all responsive documents called for under this Order on or before December 15, 2009. Plaintiffs in cases that become part of the Denture Adhesive Cream MTP after entry of this Order shall provide a completed and verified PFS, signed and dated Authorizations and all responsive documents called for under this Order within forty-five (45) days of the date of service of this Order and a copy of the PFS on the counsel for the particular Plaintiff.

6) Plaintiffs shall serve an electronic copy in form-fillable Portable Document Format (“PDF”) of the completed and verified PFS, signed Authorizations and all responsive documents by overnight delivery service on a CD-ROM or DVD-ROM.

7) Counsel for the Plaintiff shall provide a PDF version of the PFS, documents and authorizations to Plaintiffs’ Liaison Counsel.

8) If a Plaintiff who is subject to this Order fails to complete and serve the PFS, signed Authorizations or responsive documents requested in the PFS within the applicable deadline, the parties shall meet and confer in an attempt to resolve all disputes in good faith.

9) Authorizations may be provided by the Plaintiff in one of two ways:

(a) Authorizations may be signed “in blank” (that is, without setting forth the identity of the custodian of the records or provider of care) for the types of providers applicable according to Section III.(A)(2)-(4) above. Plaintiff must leave the authorizations undated. Plaintiff shall indicate on the authorization whether the authorization allows disclosure to GSK and/or P&G, and Defendants shall not change this indication. The particular Defendant named in the case may complete the authorizations for the providers and other sources of information and records identified in the PFS.

(b) Authorizations may be signed and limited to specific providers and other sources of information and records identified in the PFS (*i.e.*, setting forth the identity of the custodian of the records or provider of care). Plaintiff must leave the authorizations undated. Plaintiff shall indicate on the authorization whether the authorization allows disclosure to GSK and/or P&G, and Defendants shall not change this indication. These provider-specific Authorizations must be provided as required in Section III.(A)(2)-(4) above.

10) Defendants may request records using the Authorizations directly from the custodians of the records or through a record copy service. Defendants shall provide to Plaintiff’s counsel

information specifying each such request in the form of the Notice provided by Rule 4009.21 and 4009.24, and Plaintiff's counsel will have ten (10) days from the date of receipt of such Notice in which to notify Defendants' counsel and the third party or record copy service of any objection to production of the records to Defendants. If no such objection is made, production from the third party or record copy service to Defendants shall occur forthwith. If an objection is made, counsel shall confer concerning that objection, and if the objection cannot be resolved, Plaintiffs shall file a motion for a protective order to preclude the discovery of all or part of the records requested with this Court and the parties agree to have the Denture Adhesive Cream MTP court decide the issue. That motion shall be filed with this Court no later than ten (10) business days after the parties have conferred or reasonable attempts at conferring have failed. If said motion is filed, the third party or record copy service will not produce to Defendants, and Defendants agree not to accept or attempt to further retrieve any records from the third party or record copy service, a copy of the records subject to the request to which an objection has been made until such time as the motion is resolved. If no such motion is filed within the time provided herein, the third party or record copy service shall produce the records to Defendants. If a record copy service is used, Defendants will identify the record copy service for Plaintiffs so that Plaintiffs may request their own copy of the records from the third party or from the record copy service.

11) Defendants may not use authorizations except in accordance with this Order or by agreement of the parties. Authorizations provided by Plaintiffs are limited to release of documents only. Defendants agree not to conduct or attempt to conduct any *ex parte* interviews of any of Plaintiff's health care providers and Plaintiffs further specifically preserve and do not in any way waive Rule 4003.6 regarding discovery of treating physicians.

B. Defendants' Service Of Plaintiff Fact Sheet On Case-Specific Counsel For Plaintiff

1) For cases filed in the MTP before entry of this Order ("pre-October 16 Plaintiffs"), Defendants are not required to provide any additional service or notice to Plaintiffs' counsel of Plaintiff Fact Sheet or the related Authorizations. The due date within which Plaintiff must serve

completed Plaintiff Fact Sheet and executed Authorizations is December 15, 2009, as set forth in Section III(A)(5) of this Order.

2) For all other cases that become part of the Denture Adhesive Cream MTP after entry of this Order, the GSK Defendants or the P&G Defendants (as applicable) shall serve on Plaintiff's counsel in that case a copy of (a) Plaintiff Fact Sheet, (b) related Authorizations, (c) Case Management Order No 2. – Confidentiality Agreement and Protective Order (CMO 2); and (d) this CMO 3. The due date within which Plaintiff must serve completed Plaintiff Fact Sheet and executed Authorizations shall be forty-five (45) days from the date of service, as set forth in Section III(A)(5) of this Order. Service by Defendants as set forth in this paragraph may be accomplished (a) electronically via email, (b) by facsimile, or (c) by certified mail, return receipt requested if only a physical address is available.

3) Service on Plaintiff's counsel as described in paragraph III(B)(2) above does not constitute waiver of service, waiver of the notice requirements of Section II(A)-(B) of this CMO 3, or an appearance by the GSK Defendants or the P&G Defendants in any case.

C. Defendants' Case-Specific Profile Production

To the extent a Defendant is a named Defendant in the particular case for which a PFS has been completed under this Order, the Defendant shall provide the information and documents called for in this Section by First Class Mail or Federal Express to the particular Plaintiff's counsel and by email to Plaintiff's Liaison Counsel Eric Chaffin (chaffin@bernlieg.com). The information and documents provided by Defendants in response to this provision of this Order shall be treated as answers to interrogatories under Rule 4006 and responses to request for production of documents under Rule 4009.12 and shall be supplemented in accordance with Rule 4007.4. If a Defendant withholds or redacts any information on the basis of privilege, it shall provide Plaintiff's counsel with a Privilege Log pursuant to the Protective Order (Case Management Order Number 2 – Protective Order) previously entered by the Court.

1) **Communications With or About Plaintiff.** If Plaintiff produces documents responsive to Document Request 15 of the Plaintiffs' Fact Sheet indicating a Plaintiff-specific

communication with a Defendant, Defendant will search available consumer contact database(s) to determine whether Defendant has a record of communication with a person identified in the produced document and, not later than 45 days prior to the specific Plaintiffs' deposition, unless otherwise agreed between the specific Plaintiff and Defendant, will advise the specific Plaintiff's counsel and Plaintiffs' Liaison Counsel whether or not Defendant has a record of such communications and, if so, will produce available non-privileged documents. If the name of the person contacting Defendant is a common name, other identifying information such as address and date of the contact, may be necessary in order for Defendant to be able to search its databases effectively and Plaintiffs' counsel will cooperate in good faith to provide Defendants with the necessary information to the extent it is not already provided in the PFS. To the extent Defendant identifies any other non-privileged record of a Plaintiff-specific communication with a Defendant (other than through Plaintiff's attorney), unless otherwise agreed between the specific Plaintiff and Defendant(s), Defendant(s) will produce available non-privileged documents not later than 45 days prior to the specific Plaintiffs' deposition.

2) **Adverse Event Reports.** To the extent a search of Defendants' adverse events database (identified as OCEANS for the GSK Defendants), results in the identification of an adverse event report relating to a specific Plaintiff, other than a report resulting from Plaintiff's legal action against Defendant(s), unless otherwise agreed between the specific Plaintiff and Defendant(s), Defendant(s) shall produce any adverse event report for Plaintiff not later than 45 days prior to the specific Plaintiffs' deposition.

D. Plaintiffs' Master Requests for Production

Plaintiffs' Liaison Counsel shall develop and serve Master Set(s) of Requests Upon a Party for Production of Documents and Things pursuant to Rules 4009.1 and 4009.11 to each Defendant no later than sixty (60) days from entry of this Order. Defendants have sixty (60) days to respond. Defendants may make objections pursuant to Pennsylvania Rules of Civil Procedure. The parties shall meet and confer as soon as practicable after service of the requests to resolve disputes containing objections thereto. Plaintiffs may propound additional or Supplemental Requests for Production, including discrete subparts,

not duplicative of any prior Master Request for Production, on or before March 31, 2010. Additionally, Plaintiffs may serve a limited number of case-specific Requests for Production as set forth below. Absent agreement by Defendant(s), Plaintiffs may apply to the Court to serve additional requests for production after March 31, 2010 only upon a showing of good cause and the specific identification of the additional requests for production of documents to be served.

E. Plaintiffs' Master Set of Interrogatories

Plaintiffs Liaison Counsel shall develop and serve Master Set(s) of Interrogatories to each Defendant pursuant to Rule 4005 no later than December 11, 2009. Defendants have sixty (60) days to respond. Defendants may make objections pursuant to The Pennsylvania Rules of Civil Procedure. The parties shall meet and confer as soon as practicable after service of the interrogatories to resolve disputes containing objections thereto. Plaintiffs may propound not more than fifteen (15) additional or Supplemental Interrogatories, including discrete subparts, not duplicative of any prior Master Interrogatory, on or before March 31, 2010. Additionally, Plaintiffs may serve a limited number of case-specific Interrogatories as set forth below. Absent agreement by Defendant(s), Plaintiffs may apply to the Court to serve additional interrogatories only upon a showing of good cause and the specific identification of the additional interrogatories to be served.

F. Document Production by Defendants

1) The Defendants have produced or will produce relevant, non-privileged, discoverable documents and information related to their respective zinc-containing denture cream adhesive products. Document production by the GSK Defendants has been ongoing. The GSK Defendants have substantially completed their productions under this Section and will continue to produce relevant, non-privileged information as it is identified. The P&G Defendants have commenced their rolling productions and will produce additional documents and information as available. On a rolling basis, both the GSK Defendants and the P&G Defendants will have made a substantial production of documents on or before October 16,

2009. The Defendants will supplement their productions as additional relevant, non-privileged information is identified.

2) The parties have developed agreeable formats for initial productions of documents and information by Defendants, and each party reserves its respective rights regarding formats of productions, including specifically, the right to request or object to production of specific documents and data in native format.

3) Within thirty (30) days of entry of this Order, the Defendants shall each disclose to Plaintiffs' Liaison Counsel the existence and terms of any insurance agreement under which any person carrying on an insurance business may be liable to satisfy part or all of a judgment which may be entered in any action in the Denture Adhesive Cream MTP or to indemnify or reimburse for payments made to satisfy the judgment.

G. Privilege Logs

1) The parties will produce privilege logs in PDF format or similar electronic format. A Party will produce a privilege log within ninety (90) days after its first production of documents for which privilege is asserted to apply, and within the same time period following any subsequent or rolling productions. Privilege logs will be governed by the Protective Order (Case Management Order Number 2 – Protective Order) previously entered by the Court.

2) The use of confidential information and inadvertent production of privileged information is governed by the Protective Order previously entered by the Court.

H. Costs of Production

While each Party expressly reserves its right to seek costs relating to this litigation, including the costs of producing documents and reasonably accessible electronic documents, initially each Party will bear the costs to process, review and produce its own documents and reasonably accessible ESI.

I. Case Specific Written Discovery by Defendants as to the Individual Plaintiffs

1) *Interrogatories*. The Defendants' primary means of written discovery is the PFS. Each Defendant group (*i.e.*, the GSK Defendants and the P&G Defendants) may propound no more

than ten (10) case specific interrogatories pursuant to Rule 4005, including discrete subparts, directly to counsel of record for each Plaintiff in each respective case. Plaintiffs shall have thirty (30) days to respond. These Interrogatories may not duplicate any interrogatory contained in the PFS. Plaintiffs may make objections pursuant to the Pennsylvania Rules of Civil Procedure. The parties shall meet and confer as soon as practicable after service to resolve disputes containing objections thereto. Absent agreement by the Plaintiff, any Defendant may apply to the Court to serve additional interrogatories only upon a showing of good cause and the specific identification of the additional interrogatories sought to be served. Answers and objections to requests for production shall be served by each Plaintiff directly to counsel of record for each Defendant with a copy to Plaintiff's Liaison Counsel.

2) *Requests for Production.* The Defendants' primary means of documents requests is the PFS. Each Defendant group (*i.e.*, the GSK Defendants and the P&G Defendants) may propound no more than ten (10) requests for production pursuant to Rules 4009.1 and 4009.11, including discrete subparts, directly to counsel of record for each Plaintiff in each respective case. Defendants may not duplicate any request contained in the PFS. Plaintiffs have thirty (30) days to respond. Plaintiffs may make objections pursuant to the Pennsylvania Rules of Civil Procedure. The parties shall meet and confer as soon as practicable after service to resolve disputes containing objections thereto. Absent agreement by the Plaintiff, any Defendant may apply to the Court to serve additional document requests only upon a showing of good cause and the specific identification of the additional request(s) sought to be served. Answers and objections to requests for production shall be served by each Plaintiff directly to counsel of record for each Defendant with a copy to Plaintiff's Liaison Counsel.

J. *Case Specific Written Discovery by Individual Plaintiffs to Defendants*

1) *Interrogatories.* Individual Plaintiffs may propound no more than fifteen (15) interrogatories pursuant to Rule 4005, including discrete subparts, to each set of Defendants (*i.e.*, the GSK Defendants and the P&G Defendants) in each respective case. These Interrogatories may not duplicate any interrogatory contained in Plaintiff's Master Interrogatories to Defendants. Defendants shall have thirty (30) days to respond. Defendant(s) may make objections pursuant to the Pennsylvania

Rules of Civil Procedure. The parties shall meet and confer as soon as practicable after service to resolve disputes containing objections thereto. Absent agreement by the Defendant(s), any Plaintiff may apply to the Court to serve additional interrogatories only upon a showing of good cause and the specific identification of the additional interrogatories sought to be served. Answers to Interrogatories shall be served by Defendant(s) directly to counsel of record for the specific Plaintiff with a copy to Plaintiff's Liaison Counsel.

2) *Requests for Production.* Individual Plaintiffs may propound no more than fifteen (15) requests for production pursuant to Rules 4009.1 and 4009.11, including discrete subparts, to each Defendant group (*i.e.*, the GSK Defendants and the P&G Defendants) in each respective case. Plaintiffs may not duplicate any request contained in the Plaintiffs' Master Requests for Production to Defendants. Defendants have thirty (30) days to respond. Defendant(s) may make objections pursuant to the Pennsylvania Rules of Civil Procedure. The parties shall meet and confer as soon as practicable after service to resolve disputes containing objections thereto. Absent agreement by the Defendant(s), any Plaintiff may apply to the Court to serve additional document requests only upon a showing of good cause and the specific identification of the additional request(s) sought to be served. Answers to requests for production shall be served by Defendant(s) directly to counsel of record for the specific Plaintiff with a copy to Plaintiff's Liaison Counsel.

IV. MOTIONS

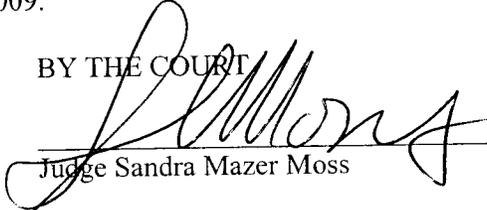
A. All discovery motions filed in the Denture Adhesive Cream Cases shall be filed in letter format and in the time frames set forth in the mass tort procedure.

V. **DEPOSITIONS**

Pursuant to Rule 4002, the parties will submit proposed orders and protocols related to the taking of depositions.

SO ORDERED, this 1st day of October, 2009.

BY THE COURT



Judge Sandra Mazer Moss

cc: Lead and Liaison Counsel for Plaintiffs and Defendants

IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

THIS DOCUMENT RELATES TO ALL CASES

**Exhibit A to
Case Management Order No. 3**

IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

PLAINTIFF: _____

Name(s)

PLAINTIFF FACT SHEET

Please provide, to the best of your knowledge and ability, the following information for each individual on whose behalf a claim is being made. If you are completing this questionnaire in a representative capacity, please respond to the questions in sections I (A), I (B), and II through XIII with respect to the person by whom Denture Adhesive Cream was allegedly used ("Denture Adhesive Cream User" or "User"). In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. If you cannot recall or determine the exact date(s) requested, then please provide your best approximation. To the extent you recall details after you submit your fact sheet, you are obligated to supplement your fact sheet with the additional information. *Please attach as many additional sheets of paper as are necessary to fully and completely answer these questions.*

In filling out this form, please use the following definitions and instructions:

(1) "Health Care Provider" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, nursing, dietary, and any pharmacy, x-ray department, laboratory, physical therapist or physical therapy department, radiologist or radiology group, dermatologist, surgeon, x-ray department or facility, rehabilitation specialist or facility, physician, osteopath, homeopath, chiropractor, podiatrist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you. "Health Care Provider" as defined herein does not include a purely "consulting expert" (as interpreted and defined by governing rules, and subject to the provisions and limitations of the Pennsylvania Rules of Civil Procedure) who: (1) has been specifically retained by your counsel in this Lawsuit to evaluate or diagnose your medical and/or mental condition; and (2) has not, outside of this retained role, ever been involved in your evaluation, diagnosis, care and/or treatment.

(2) "Oral Health Care Provider" means any dentist, oral surgeon, endodontist, periodontist, prosthodontist, denturist, orthodontist, dental hygienist, other provider of dental or oral health care, as well as any dental office, facility or clinic that is associated with such persons.

(3) "Document" means any writing or record of every type that is in your possession, custody or control, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings,

graphs, phone records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

I. Case Information

A. Name of person completing this form: _____

B. Please state the following for the civil action that you filed:

1. Name of the Denture Adhesive Cream User: _____

2. Case caption: _____

3. Name, address, telephone number, fax number and e-mail address of principal attorney representing you:

Name

Firm

Street Address

City, State and Zip Code

Telephone Number

Fax Number

E-mail address

C. If you are completing this questionnaire in a representative capacity (on behalf of the estate of a deceased person, incapacitated person, or a minor), please state:

1. Your name: _____

2. Address: _____

3. In what capacity you are representing the individual: _____

4. If you were appointed by a court, state the court and date of appointment: _____

5. Your relationship to deceased or represented person: _____

6. If you represent a decedent's estate, state the date of death of decedent: _____

II. Personal Data of the Denture Adhesive Cream User¹

A. Maiden name or any other names used and dates of use: _____

B. Identify each address at which you have resided since 1995 to the present, starting with your current address, and list when you started and stopped living at each address:

Address	Dates of Residence

C. Driver's License Number and State Issuing License: _____

D. Social Security Number: _____

E. Date and place of birth: _____

F. Sex: Male _____ Female _____

G. For your current and each former marriage, please list the following information for each spouse:

Name and Current Address of Spouse, if known	Date of Birth	Date of Marriage, if applicable	Date Marriage Ended, if applicable	How Marriage Ended	Occupation (current spouse only)

H. Has your spouse filed a loss of consortium claim in this action? Yes _____ No _____

I. For each of your children, state his/her name, age, and state of residence: _____

¹ In sections II through XIV, the Denture Adhesive Cream User is also referred to as "User," "you" or "your."

J. Employment Information.

Beginning with your current employer (if not currently employed, last employer), list the following for each employer you have had since 1995 to the present:

Name	Address	Dates of Employment	Job Title

K. Education. Please identify the schools you have attended (high school and beyond):

Name of School	Address	Dates of Attendance	Degree or Diploma Awarded and Date Received	Major or Primary Field of Study

L. Have you ever applied for worker's compensation, social security, or state or federal disability benefits? Yes _____ No _____

If "yes," then as to each application, separately state:

1. Date (or year) of application, type of benefits, and the reason for your claim: _____

2. Amount awarded or stated reason for denial, if denied:

3. To what agency or company did you submit your application (for example, Pennsylvania Division of Social Security): _____

M. Have you ever been out of work for more than thirty (30) days in any one (1) year for reasons related to your health condition (other than pregnancy)? Yes _____ No _____

If "yes," please state the dates you were out of work, your employer, if any, on those dates, and describe the condition(s) that kept you from working:

N. Have you ever served in the U.S. Military? Yes _____ No _____

If "yes," were you ever rejected or discharged from military service for any stated reason relating to your health, physical, emotional or psychiatric condition? Yes _____ No _____

If "yes," describe the condition and the date upon which you were rejected or discharged from military service, and identify the military branch in which you were serving, or were considered for service, at that time. _____

O. Within the past 20 years, have you filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury, sickness or disease? Yes _____ No _____

If "yes," state the court in which such action was filed, the case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action, or suit. _____

Have you *ever* filed a lawsuit or made a claim, other than in the present suit, relating to the same or similar injuries or conditions you claim in this case? Yes _____ No _____

If "yes," state the court in which such action was filed, the case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action, or suit. _____

P. In the last 10 years, have you been convicted of or pled guilty to any felony and/or have you been convicted of or pled guilty to *any* crime that involved an alleged act of dishonesty or providing a false statement? Yes _____ No _____

If "yes," state the date of such conviction or plea, the court in which such conviction or plea was entered and the nature of the felony and/or other crime. _____

III. Oral Health Care Providers of the Denture Adhesive Cream User

- A. Please list to the best of your knowledge every Oral Health Care Provider (beginning with your *current* dentist) whom you have seen or from whom you have ever received oral or dental care or treatment (including fitting and treatment for dentures, repair and/or replacement of dentures) since 5 years before you first got denture(s) to the present. Please **circle** the Name of the Oral Health Care Provider that you *last* saw for any reason.

Full Name and Specialty, if any	Complete Address	Treatment Provided	Approximate Dates

IV. Dentures

A. Use of Dentures

1. Reason you use dentures:

a. Please describe in your own words why you need dentures (for example, an accident causing tooth loss (describe accident), loss of tooth enamel or bone, mouth or gum disease, lack of oral hygiene, or other reason). _____

b. If any Oral Health Care Provider or Health Care Provider told you about a medical or oral condition requiring you to use dentures, please state the Provider's full name and address, the date(s) the Provider informed you, and what you were told by the Provider. _____

2. Please provide the following information for any tooth extraction done in preparation for denture use:

a. number of teeth extracted: _____

b. location of teeth extracted: _____

- c. name of Oral Health Care Provider or Health Care Provider performing extraction: _____
- d. date of extraction: _____
3. Date of first use of dentures: _____
4. Date of last use of dentures (if ongoing, please state): _____
5. State the type of dentures you wear/have worn and the approximate beginning and ending dates you wore each: (a) uppers only; (b) lowers only; (c) both uppers and lowers; (d) partials; (e) other (please specify): _____

6. The last date you saw an Oral Health Care Provider *regarding your dentures* and the name of the Provider seen: _____

V. **Denture Adhesive Creams**

- A. With respect to your use of *any* Denture Adhesive Cream at any time (including but not limited to Poligrip and/or Fixodent)

Please answer the following:

Brand <i>and</i> Type of each Denture Adhesive Used	Date of First Use and Dates of Any Later Use	Name(s) of Oral Health Care Provider(s), if any, that you were seeing during the time period you indicate in Column 2

- B. Prior to or during your use of any denture adhesive cream, were you given any information by any Oral Health Care Provider(s) or Health Care Provider(s) regarding use of denture adhesive cream (information may include oral or written instructions, directions, advice, warnings, or other types of information)? Yes _____ No _____

If yes, please state:

1. The date(s) on which such oral instructions, directions, advice, warnings, or other information regarding use of denture adhesive cream were given to you:

2. Name and address of any Oral Health Care Provider or Health Care Provider who gave the oral instructions, directions, advice, warnings or other information regarding use of denture adhesive cream to you: _____

3. To the best of your ability, describe what you were told about the use of denture adhesive cream by *each* Oral Health Care Provider or Health Care Provider you identified in 2 above.

Provider 1 [Name of Provider and Information Given]: _____

Provider 2 [Name of Provider and Information Given]:

Provider 3 [Name of Provider and Information Given]: _____

VI. Medical Background of the Denture Adhesive Cream User

A. General Background

1. Height: _____
2. Current Weight: _____

B. Smoking/Tobacco Use History

1. Ever smoked cigarettes? Yes ___ No ___
 - a. If "yes," provide the date you started smoking: _____

2. Current smoker of cigarettes? Yes ___ No ___
 - a. If "yes," state the number of packs smoked per day: _____

3. Former smoker of cigarettes? Yes ___ No ___
 - a. If "yes," provide the date you permanently stopped smoking: _____
 - b. If "yes," state the number of packs smoked per day before you permanently stopped: _____

4. Any other form of tobacco use (pipe tobacco, snuff, chewing tobacco, dipping, cigars)? Yes _____ No _____

a. If "yes," then state what form, dates of use, and amount of use as to each:

5. Has the number of cigarettes smoked per day, or other daily tobacco use, changed over the last 5 years? Yes _____ No _____

a. If "yes," then please briefly describe the change in usage of each:

C. Alcohol Consumption

1. Have you in the past drunk alcohol (beer, wine, whiskey, etc.)? Yes _____ No _____

a. If "yes," provide the date you started consuming alcohol:

2. Do you currently drink alcohol? Yes _____ No _____

a. If yes, check below which best describes your alcohol consumption.

- _____ Less than 1 drink per week
- _____ Less than 1 drink per month
- _____ 1-5 drinks per week
- _____ 6-10 drinks per week
- _____ 10 or more drinks per week
- _____ 20-30 drinks per month
- _____ 30-40 drinks per month
- _____ Over 40 drinks per month

b. If you have ever but do not currently drink alcohol, check below which best describes your former alcohol consumption.

- _____ Less than 1 drink per week
- _____ Less than 1 drink per month
- _____ 1-5 drinks per week
- _____ 6-10 drinks per week
- _____ 10 or more drinks per week
- _____ 20-30 drinks per month
- _____ 30-40 drinks per month
- _____ Over 40 drinks per month

3. If you have ever but do not currently drink alcohol, provide the date you last consumed any alcohol: _____

4. Has your weekly or monthly alcohol consumption pattern changed over the last 5 years? Yes _____ No _____

a. If "yes," then please describe the change: _____

D. Illicit Drugs

1. Have you ever used marijuana regularly (more than once a month) during a period of 3 or more consecutive months? Yes _____ No _____ Don't Recall _____

a. If "yes," please state how often you used it, and the date of your last use:

2. Have you ever regularly used (more than once a month) any illicit drugs, other than marijuana, during a period of 3 or more consecutive months (examples include but are not limited to: cocaine/crack cocaine; heroin, opiates, or methadone; hallucinogens such as LSD, Ecstasy, ICE, PCP, MDMA or similar substances; amphetamines, crystal meth, or other stimulants; barbiturates or other sedatives)?

Yes _____ No _____

If "yes," please state what you used, how often you used it, and the date of your last use: _____

E. Nutritional History

1. Have you ever followed any special diets or dietary restrictions for more than 3 consecutive months, for example, for the purpose of weight loss, a health condition such as diabetes or high blood pressure, allergic reactions, or other reason? Yes _____ No _____

If "yes," for each type of diet listed below, give a general description of the diet, the dates you followed that diet, the reason for the diet (for example, to lose weight; to control blood pressure, diabetes, or allergies; to correct nutritional or other imbalance), whether the diet was prescribed or recommended by a health care provider, and if so, the name of the health care provider.

a. Diet or nutritional program you designed yourself:

b. Physician-prescribed diet:

c. Any other diet program (examples include Adkins, South Beach, Pritikin, Jenny Craig, Weight Watchers, vegetarian, low fat, high protein, gluten-free, etc.)

2. Do you regularly drink soda or other carbonated beverages? Yes ____ No ____

If "yes," please state the type of the soda you drink, whether diet or regular, and the amount of soda you drink per day. _____

F. To the best of your knowledge have you ever suffered from or been diagnosed by a doctor or other health care provider with:

	Yes	No	I Don't Recall
1. Anemia	_____	_____	_____
2. Leucopenia	_____	_____	_____
3. Neutropenia	_____	_____	_____
4. Hypocupremia or Copper Deficiency	_____	_____	_____
5. Hyperzincemia or Zinc Overload	_____	_____	_____
6. Vitamin B12 Deficiency	_____	_____	_____
7. Other Vitamin Deficiency	_____	_____	_____
8. Myelodysplasia	_____	_____	_____
9. Myelofibrosis	_____	_____	_____
10. Diabetes	_____	_____	_____
11. Wilson's Disease	_____	_____	_____
12. Menkes' Disease	_____	_____	_____
13. Myasthenia Gravis	_____	_____	_____
14. Multiple Sclerosis	_____	_____	_____
15. Parkinson's Disease	_____	_____	_____
16. Amyotropic Lateral Sclerosis (ALS; Lou Gehrig's Disease)	_____	_____	_____
17. Alzheimer's Disease	_____	_____	_____
18. Cancer/Malignancy	_____	_____	_____
19. Uremia	_____	_____	_____
20. Liver Disease	_____	_____	_____

- 21. Rheumatoid Arthritis _____
- 22. Celiac Disease _____
- 23. Inflammatory Bowel Syndrome or Disease _____
- 24. Small Intestine/Bowel Bacterial Overgrowth _____
- 25. Other Malabsorption or Gastrointestinal Disorder _____
- 26. Short Bowel Syndrome _____
- 27. Gastric or Intestinal Ulcers _____
- 28. Aceruloplasminemia _____
- 29. Any Immunologic or Autoimmune disorder _____
- 30. Head, Neck, or Back Trauma or Injury _____
- 31. Brain Injury _____
- 32. Cognitive Deficits _____
- 33. Injury to Spinal Cord _____
- 34. Disease or injury of vertebra or disc _____
- 35. Occipital Horn Syndrome _____
- 36. Subacute Combined Degeneration of the Spinal
Cord _____
- 37. Myelopathy (disease or injury of spinal column) _____
- 38. Neuropathy or Peripheral Neuropathy (disease or
injury to nerves other than spinal column) _____
- 39. Myeloneuropathy or Combined Systems Disease _____
- 40. Anorexia Nervosa _____
- 41. Bulimia Nervosa _____
- 42. Malnutrition _____
- 43. Any Neurologic (nerve) Disease or Disorder _____
- 44. Any Hematologic (blood) Disease or Disorder _____

If "yes," please state separately for each:

Type of Condition	Date of First Symptoms	Date of Diagnosis	Diagnosing Doctor

G. Have you ever undergone dialysis, tube feeding, and/or intravenous feeding? If so, please provide the reason(s) for such treatment, and frequency and dates of such treatment: _____

H. Have you ever had bariatric, gastrointestinal and/or other weight loss surgery? If so, please provide the reason(s) for the surgery, the date of the surgery, the name of the surgeon who performed the surgery, and the facility at which the surgery was performed: _____

VII. Medications, Vitamins, or Supplements Used by the Denture Adhesive Cream User

To the best of your knowledge, state whether you used any of the following medications, vitamins or supplements at any time beginning 5 years before your first use of any denture adhesive cream to the present OR in the past 15 years, whichever date is earlier. Circle all medications you have used, state the first and last dates you took the medication, and identify the doctor that prescribed the medication, vitamins or supplements.

Medication	Dates Used (first to last use)	Prescribing Doctor, if applicable	Reason for Use/Prescription, if applicable
Any Multivitamin preparation (including but not limited to Centrum, One-A-Day, Stuart, Oncovite, Nature Made, Stresstabs, Weil, Prescriptive Formulas, Vitafusion, Viactiv, Rite Aid, Walgreens, Twinlab, Geritol, Natrol)			

Medication	Dates Used (first to last use)	Prescribing Doctor, if applicable	Reason for Use/Prescription, if applicable
Any supplements, sprays, swabs, lozenges, or other products containing Zinc (including but not limited to GNC Zinc 50, GNC Zinc 100, ICaps, Ocuvite, Sunkist Zinc Throat Lozenges, Tung Gel, Zand Herbalozenge, GNC Ultra Zinc Lozenges, Cold-Eeze, TheraBreath Chewing Gum, EAS Myoplex, Zicam Cold Remedy Nasal Gel or Gel Swaps, Zicam Cold Remedy, Zicam Healthy Z-ssentials)			
Any and all <u>other</u> prescription and non-prescription medications, including vitamin supplements, herbal supplements or remedies, or homeopathic remedies.			
Name: _____ _____ _____ _____ _____ _____ _____ _____			

VIII. Injuries, Symptoms, Diagnoses, Ailments, and Damages of the Denture Adhesive Cream User

A. Are you claiming that you have developed or may develop any injury or damage or condition (including any alleged physical, injury or damage) as a result of using denture adhesive cream? Yes _____ No _____

If "yes," then for *each* such injury, damage or condition, answer the following:

1. Describe each injury, damage or condition that you are claiming was caused by your use of any Denture Adhesive Cream, including in your description the date you became aware of each injury, damage or condition:

2. Describe all of the symptoms you are experiencing that you claim result from use of denture adhesive cream.

3. For each of the symptoms you describe in No. 2 above, going back ten (10) years from your first use of dentures, when was the *first time* (the earliest date) you can remember ever having that symptom, , even if the symptom went away:

Symptom: _____
First Time (earliest date): _____

4. For each such injury, damage, condition, or symptom that you have described in this Section VIII (A) (1-2) above, have you consulted with any Health Care Provider(s) or Oral Health Care Provider(s) with respect to your alleged denture adhesive cream-related injury(ies)? Yes _____ No _____

If "yes," for each Health Care Provider or Oral Health Care Provider, state:

Name of Health Care Provider or Oral Health Care Provider	Address of Health Care Provider or Oral Health Care Provider	Dates of Consultation/Treatment and Nature of Injury, Damage, Condition or Symptom

B. Did you ever suffer from these types of injuries, damages, or conditions, or have any symptoms of these types of injuries, damages, or conditions, prior to your use of denture adhesive cream? Yes _____ No _____

If "yes," for each such injury, damage, condition or symptom, state:

Description of Injury, Damage, Condition or Symptom	Date(s) You Had the Injury, Damage, Condition or Symptoms	Health Care Provider or Oral Health Care Provider Visited, if any	Dates of Consultation/Treatment with Health Care Provider or Oral Health Care Provider, if any

C. Have you ever undergone any of the following medical tests?

1. Magnetic Resonance Imaging (MRI) of the brain: Yes _____ No _____
2. Magnetic Resonance Imaging (MRI) of the spine: Yes _____ No _____

3. Electromyogram (EMG): Yes _____ No _____ Unsure _____
4. Evoked Potentials Tests (including but not limited to Somatosensory Evoked Potentials (SSEP) tests): Yes _____ No _____ Unsure _____
5. Nerve Conduction Velocity Study (NCVS): Yes _____ No _____ Unsure _____

If "yes" to any of the above, please state for *each*:

- a. The name of *each* test:

- b. The date *each* test was ordered: _____
- c. The Health Care Provider that ordered *each* test: _____
- d. The date and location where *each* test was administered: _____
- e. Your best knowledge and information as to whether *each* test showed any problem, and, if so, what each test showed and/or what you were told by any Health Care Provider that each test showed: _____

D. Do you allege that the use of denture adhesive cream aggravated a pre-existing condition?
Yes _____ No _____

If "yes," for each such pre-existing condition, state:

- a. A Description of the Pre-Existing Condition: _____
- b. The date when any pre-existing condition first arose: _____

c. The date any pre-existing condition was first diagnosed: _____

d. The name and address of any healthcare provider or oral health care provider who provided care for any pre-existing condition: _____

E. Have you ever had laboratory work performed that measured your whole blood, serum, plasma, or urine levels for zinc, copper and/or ceruloplasmin?
Yes _____ No _____ Unsure _____

If "yes," then based on your best recollection, separately state for zinc, copper and/or ceruloplasmin *each* time they were measured:

a. The zinc, copper and/or ceruloplasmin level(s) found and whether the level(s) were low, normal or high. (If specific level is unknown, please provide/describe your best knowledge and information about whether the result(s) were low, normal, or high as to each test performed and/or what you were told as to whether your zinc and/or copper level(s) were low, normal or high): _____

b. The date(s) the blood was drawn (or urine sample provided): _____

c. The lab or facility that performed the test: _____

d. The type of test (whole blood, serum, plasma, or urine): _____

F. Has any Health Care Provider or Oral Health Care Provider told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages, conditions, or symptoms that you describe in this Section VIII above are associated with your use of any denture adhesive cream? Yes _____ No _____

If "yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told:

2. (a) The name(s) of the Health Care Provider or Oral Health Care Provider who told you (or your agents, representatives or anyone acting on your behalf) and (b) when:

- G. Has any Health Care Provider or Oral Health Care Provider ever told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages or conditions that you describe in this Section VIII above are associated with any factors *other than* your use of any denture adhesive cream? Yes _____ No _____

If "yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told:

2. (a) The name(s) of the Health Care Provider or Oral Health Care Provider who told you (or your agents, representatives or anyone acting on your behalf) and (b) when:

- H. Excluding future medical expenses are you claiming that you have paid or will have to pay any expenses as a result of having used any denture adhesive cream? Yes _____ No _____

If "yes," then for each item separately identify:

Reason Expense was Incurred	Amount of Fees or Expenses	Person or Company Paid or to be Paid

- I. Are you claiming to have suffered any mental anguish or emotional injury as a consequence of using any denture adhesive cream?

Yes _____ No _____

If "yes," have you received any counseling/care/treatment by any mental health care provider for the mental anguish or emotional injury you are claiming?

Yes___ No___

If "yes," then state:

The full name, address and specialty of each mental health care provider you have seen for the mental anguish or emotional injury you are claiming, and the approximate date(s) of any visits with each: _____

J. Do you claim psychological or psychiatric injury (other than the mental anguish or emotional distress described above) as a consequence of using any denture adhesive cream.

Yes___ No___

If "yes," have you received any counseling/care/treatment by any mental health care at any time for any psychological or psychiatric conditions?

Yes___ No___

If "yes," then state:

The full name, address and specialty of each mental health care provider you have *ever seen for any reason* and the approximate date(s) of any visits with each: _____

K. Fact Witnesses

Please identify all persons who you believe possess information concerning your claimed injury(ies) and damages other than your Healthcare Providers and/or Oral Healthcare Providers, and please state their name address and his/her/their relationship to you:

Name: _____

Address: _____

Relationship to you: _____

Name: _____

Address: _____

Relationship to you: _____

Name: _____

Address: _____

Relationship to you: _____

IX. Family History of the Denture Adhesive Cream User

A. To the best of your knowledge did any child, parent, sibling, or grandparent of the Denture Adhesive Cream User have any of the conditions or experiences identified in Section VI (F) beginning on page ____?

Yes _____ No _____ Unsure _____

B. If "yes," or "unsure," then based on your best recollection, state separately for each person the relationship to you, the type of health problem, and the date and cause of death (if applicable): _____

X. Health Care Providers of the Denture Adhesive Cream User

A. Provide the requested information for each of the following Health Care Providers and health care facilities:

Beginning with your current family and/or primary care physician(s), please list your family and/or primary care physicians in the time period from 10 years preceding your first use of dentures to the present.

Name	Address	Approximate Dates

- B. Provide the requested information for each hospital, clinic, or health care facility where you have received inpatient or outpatient treatment (including treatment in an emergency room) or been admitted as a patient during the time period from 10 years preceding your first use of dentures to the present.

Name	Address	Admission/ Treatment Dates	Reason for Admission/ Treatment	Treatment Received

- C. Provide the requested information for each surgery or operation that you have ever undergone, including oral surgery but not including surgery related to childbirth.

Name and Address of Hospital, Treating Physician and Surgeon	Type of Surgery or Operation	Date of Surgery or Operation	Reason for Surgery or Operation

- D. Provide the information requested for every other Health Care Provider (as defined at beginning of this questionnaire) or facility (not identified in A-C above) whom you have seen or consulted or from whom you have received treatment, evaluation, or testing for *any* reason, or at which you've been treated, evaluated or tested for *any* reason, during the time period of 10 years preceding your first use of dentures to the present.

Name and Specialty, if any	Address	Dates of Treatment/ Admission/ Visit	Reason for Treatment/ Admission/Visit	Treatment Received

E. Provide the requested information for each pharmacy that has dispensed medication to you for the time period of 10 years preceding your first use of dentures to the present:

Name	Address	Years When You Used Pharmacy

XI. Insurance Providers of the Denture Adhesive Cream User

A. Have you ever had health, prescription, dental, disability, or worker's compensation insurance coverage at any time? Yes ____ No ____

If "yes," then as to each insurance provider, please provide:

Insurance Provider Name and Address/ Telephone Number, if available	Name and Address of Policy Holder/Insured (if different than you)	Subscriber/ Group ID Number and Policy/ Identification Number	Approximate Dates of Coverage	Type of Coverage (e.g., health, dental, comp)

B. Have you ever been denied health, dental, or disability insurance coverage? Yes ____ No ____

If "yes," state the date of such denial, the name of the insurance company, and the stated reason for such denial, if known. _____

C. Have you ever been denied life insurance? Yes ____ No ____

If "yes," state the date of such denial, the name of the insurance company, and the stated reason for such denial, if known. _____

XII. Use of Poligrip

If you have used Poligrip denture adhesive cream at any time, please answer the following questions. If not, please leave blank.

- A. Date of first use of Poligrip: _____
- B. Date of last use of Poligrip (if ongoing, please state): _____
- C. If you have discontinued your use of Poligrip, state the reason you stopped using Poligrip:

- 1. If you discontinued your use of Poligrip, were you advised to stop using Poligrip by a Health Care Provider or Oral Health Care Provider? Yes _____ No _____
- 2. If you answered yes above, state the name of the Provider and the approximate date you were so advised: _____

- D. Did you use Poligrip continuously during the time period described in (A) and (B) above?

- E. If you did not use Poligrip continuously, state the dates or time periods you used Poligrip:

- F. The type(s) of Poligrip you normally use or used (for example, Super Poligrip Original, Super Poligrip Free, Super Poligrip Ultra Fresh, Super Poligrip Extra Care with Poliseal, or other): _____

- G. The tube size of Poligrip you normally purchase or purchased (for example, 2.4 oz [68g], 1.4 oz [40g], or other): _____

- H. If you have used more than one type of Poligrip, state the type of Poligrip and the approximate dates or time periods of use of each: _____

- I. The number of times per week you use/used Poligrip (and, if different over time, describe and provide the dates or time periods of each such usage): _____

J. For your *upper* denture, the number of times per day you apply/applied Poligrip to your upper dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____

K. For your *lower* denture, the number of times per day you apply/applied Poligrip to your lower dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____

L. Did you or do you clean your dentures before each application of Poligrip? Yes___ No___
Sometimes _____

1. If you answered yes or sometimes, please describe your denture cleaning process: _____

M. Do you have other dental appliance(s) (for example, bridge, plate, mouth guard, crown) to which you applied/apply Poligrip? Yes___ No___

1. If yes, please identify the appliance(s) and the number of times per day that you use Poligrip with each appliance: _____

N. Every store or pharmacy where Poligrip was purchased by you or on your behalf and the approximate dates of purchase: _____

O. Identify every Oral Health Care Provider from whom you received Poligrip: _____

P. The number of 2.4 oz tubes of Poligrip you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____

2. one month: _____

3. 6 months: _____

4. 1 year: _____
5. Other (for example, one 2.4 oz tube every 10 days): _____

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

Q. The number of 1.4 oz tubes of Poligrip you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____
2. one month: _____
3. 6 months: _____
4. 1 year: _____
5. Other (for example, one 1.4 oz. tube every 10 days)

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

R. Briefly describe, separately as to your *upper* denture and *lower* denture, your typical application process of Poligrip to your dentures, including *but not limited to* (a) whether you use separate drops or a solid line of adhesive on each denture; (b) where on each denture you apply adhesive; (c) whether your typical application results in any ooze or overflow. (If your application process has changed over the years, separately describe each application process used and provide the dates or time periods of each such usage.)

XIII. Use of Fixodent

If you have used Fixodent denture adhesive cream at any time, please answer the following questions. If not, please leave blank.

- A. Date of first use of Fixodent: _____
- B. Date of last use of Fixodent (if ongoing, please state): _____

C. If you have discontinued your use of Fixodent, state the reason you stopped using Fixodent:

1. If you discontinued your use of Fixodent, were you advised to stop using Fixodent by a Health Care Provider or Oral Health Care Provider? Yes _____ No _____

2. If you answered yes above, state the name of the Provider and the approximate date you were so advised: _____

D. Did you use Fixodent continuously during the time period described in (A) and (B) above? _____

E. If you did not use Fixodent continuously, state the dates or time periods you used Fixodent: _____

F. The type(s) of Fixodent you normally use or used (for example, Fixodent Complete, Fixodent Fresh, Fixodent Free, Fixodent Original, Fixodent Comfort, Fixodent Control, Fixodent Control + Scope Flavor, or other): _____

G. The tube size of Fixodent you normally purchase or purchased (for example, 1.4 oz., 2.0 oz., 2.2 oz., 2.4 oz., other): _____

H. If you have used more than one type of Fixodent, state the type and the approximate dates or time periods of use of each: _____

I. The number of times per week you use/used Fixodent (and, if different over time, describe and provide the dates or time periods of each such usage): _____

J. For your *upper* denture, the number of times per day you apply/applied Fixodent to your upper dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____

K. For your *lower* denture, the number of times per day you apply/applied Fixodent to your lower dentures (and, if different over time, describe and provide the dates or time periods of each such usage): _____

L. Did you or do you clean your dentures before each application of Fixodent? Yes__ No__
Sometimes ____

1. If you answered yes or sometimes, please describe your denture cleaning process: _____

M. Do you have other dental appliance(s) (for example, bridge, plate, mouth guard, crown) to which you applied/apply Fixodent? Yes__ No__

1. If yes, please identify the appliance(s) and the number of times per day that you use Fixodent with each appliance: _____

N. Every store or pharmacy where Fixodent was purchased by you or on your behalf and the dates of purchase: _____

O. Identify every Oral Health Care Provider from whom you received Fixodent: _____

P. The number of 2.4 oz tubes of Fixodent you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____

2. one month: _____

3. 6 months: _____

4. 1 year: _____

5. Other (for example, one 2.4 oz tube every 10 days): _____

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

Q. The number of 1.4 oz tubes of Fixodent you use/used in *each* of the following time periods: [Answer each subpart separately]

1. one week: _____
2. one month: _____
3. 6 months: _____
4. 1 year: _____
5. Other (for example, one 1.4 oz tube every 10 days): _____

If the number of tubes you use/used changed over time, describe and provide the dates or time periods of each such usage:

R. Briefly describe, separately as to your *upper* denture and *lower* denture, your typical application process of Fixodent to your dentures, including *but not limited to* (a) whether you use separate drops or a solid line of adhesive on each denture; (b) where on each denture you apply adhesive; (c) whether your typical application results in any ooze or overflow. (If your application process has changed over the years, separately describe each application process used and provide the dates or time periods of each such usage.)

XIV. Request for Production of Documents Directed to Plaintiff(s)

Please produce the following non-privileged documents (including but not limited to emails and internet articles or postings) with this Fact Sheet, to the extent that such documents are currently in your possession or in the possession of your lawyers:

1. All documents you or anyone acting on your behalf reviewed in preparation of this Fact Sheet.
2. A copy of all medical records regarding the Denture Adhesive Cream User from any Health Care Provider who treated the Denture Adhesive Cream User for any disease, condition or symptom referred to in response to the questions above.
3. A copy of all dental records regarding the Denture Adhesive Cream User from any Oral Health Care Provider who has treated the Denture Adhesive Cream User for any reason, including for the care and fitting of dentures.

4. To the extent not included in the foregoing, all records relating to any examination of the Denture Adhesive Cream User by any Health Care Provider or Oral Health Care Provider, conducted for any purpose during the time period of 10 years preceding your first use of dentures to the present.
5. A copy of any and all purchase receipts showing proof of purchase of Poligrip or Fixodent by the Denture Adhesive Cream User or on his or her behalf.
6. If the Denture Adhesive Cream User has been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.
7. Reports of all diagnostic tests, including but not limited to blood tests, peripheral blood smears, bone marrow smears or testing, electromyograms, nerve conduction studies, somatosensory evoked potential studies, visual evoked potential studies, brainstem auditory evoked potential studies, other neurological testing, X-rays, MRIs, CT scans, and other imaging studies administered to the Denture Adhesive Cream User at any time.
8. Copies of all documents in your possession from physicians, Health Care Providers, Oral Health Care Providers or others relating to the use of Denture Adhesive Cream, or to any condition you claim is related to the use of Denture Adhesive Cream, or recording or reflecting the use of any Denture Adhesive Cream by the Denture Adhesive Cream User.
9. All documents constituting, concerning, or relating to product use instructions, product warnings, package inserts or other materials obtained by the Denture Adhesive Cream User or his or her agents, representatives or anyone acting on the Denture Adhesive Cream User's behalf (other than your attorneys in this case) in connection with the use of any Denture Adhesive Cream, including but not limited to Poligrip and/or Fixodent. This request seeks documents already in your possession, or that come into your possession, that were and/or are obtained by you from any source other than the documents that Defendants either have or may produce during the course of discovery in this lawsuit.
10. All prescriptions, prescription records, drug containers and labels, informational brochures, advertisements, package inserts and other documents setting forth warnings and/or instructions relating to any medications, drugs, vitamins or supplements used by the Denture Adhesive Cream User as identified in Section VII of this Fact Sheet.
11. Any diaries, calendars, date books, or other documents which reflect use by the Denture Adhesive Cream User of any medications, drugs, vitamins or supplements and/or which record or reflect the occurrence, duration, or severity of any injury, illness, or disease affecting the Denture Adhesive Cream User within the time period of 10 years preceding your first use of dentures to the present.

12. Any releases, covenants not to sue, and any other agreement(s) between you and any other person relating in any way to the claims asserted in this lawsuit.
13. All press releases or other public statements made by or on behalf of you relating to this litigation (excluding postings on web sites of plaintiffs' attorneys).
14. All documents recording, reflecting or relating to any communication concerning Denture Adhesive Cream (including but not limited to Poligrip and/or Fixodent) that you or anyone acting on your behalf had with any governmental body, regulatory agency, trade group, pharmaceutical manufacturer or distributor, members of the press or news media, or other person (other than any communication with your lawyers in this case).
15. All documents recording, reflecting or relating to any communication that you or anyone acting on your behalf (including your attorneys) has had with any of the GSK Defendants and/or the P&G Defendants, including but not limited to any electronic or tape recording of any such communication(s).
16. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.
17. All documents that relate to Denture Adhesive Creams (including but not limited to Poligrip and/or Fixodent), any alleged side effect of Denture Adhesive Cream, or the alleged injuries that are the subject of this lawsuit. This request seeks documents already in your possession, or that come into your possession, that were and/or are obtained by you from any source other than the documents that Defendants either have or may produce during the course of discovery in this lawsuit.
18. All documents relating to Denture Adhesive Creams or any alleged health risks or hazards related to Denture Adhesive Creams in your possession, or the possession of the Denture Adhesive Cream User, at or before the time of the injury alleged in your Complaint.
19. All documents you or anyone acting on your behalf (and not your lawyer) obtained directly or indirectly from any defendant.
20. All photographs, drawings, journals, slides or videos relating to the injuries alleged in your complaint (excluding materials prepared by Plaintiffs' experts, the production of which will be separate).
21. All documents that record, reflect or relate to any pecuniary loss or other damages, including all out of pocket expense documentation, that you claim resulted from the administration of any Denture Adhesive Cream as alleged in the Complaint.

**IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA**

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

THIS DOCUMENT RELATES TO ALL CASES

**Exhibit B to
Case Management Order No. 3**

22. If your complaint includes a claim of loss of support or loss of earnings or earning capacity, produce all W-2s (if you are an employee) and/or the federal income tax returns (if you are self-employed) of the Denture Adhesive Cream User since 1995 to the present.
23. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.
24. Copies of letters testamentary, letters of administration or similar documentation relating to your status as plaintiff (if applicable).
25. Decedent's death certificate (if applicable).
26. Medical or coroner's reports regarding decedent's death (if applicable).

XV. Authorizations

Complete and sign the attached authorizations for release of records.

XVI. Declaration

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct, that I have supplied all the documents requested in Section XIV of this Plaintiffs' Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

Signature

Date

Printed Name

IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

PLAINTIFF: _____
Name(s)

**AUTHORIZATION TO DISCLOSE HEALTH AND INSURANCE INFORMATION
PURSUANT TO 45 CFR 164.508 (HIPAA)**

TO: _____
Name of Healthcare Provider/Physician/Facility

Address (Street, City, State, Zip Code)

RE: Patient Name: _____
Date of Birth: _____ Social Security Number: ____ - ____ - ____
Address: _____

I, _____, hereby authorize you to release and furnish to [Check one or both]:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G) _____;

and/or her/his/their designated agent, **HG Litigation Services**, copies of full and complete protected medical and health information, including the following:

For use in the In Re: Denture Adhesive Cream Litigation, June Term 2009, No. 4534. To my healthcare provider: This authorization is forwarded by attorneys for defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me, unless you receive a separate and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the records, or any other matter bearing on my medical or physical condition at a deposition or trial.

- All health information records, including medical, dental and medication records, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians or health care providers.

- All autopsy, laboratory, pathology, histology, cytology, hematology, radiology, CT scan, MRI, EMG, X-rays, Evoked Potentials Tests, SSEP tests, Nerve Conduction Velocity Studies (NCVS), echocardiogram and cardiac catheterization reports.
- All radiology films, CT scans, MRIs, Evoked Potentials tests, SSEP tests, Nerve Conduction Velocity Studies, X-rays, EMGs, mammograms, myelograms, photographs, bone scans, tracings, recordings, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.
- All pharmacy/prescription records including NDC numbers and drug information handouts/monographs
- All billing information, including all statements, itemized bills, insurance records and Medicare/Medicaid claims applications.

I understand that the information in my health record 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, and treatment of alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. 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 at conclusion of my involvement in the captioned litigation.*

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that 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. If I have questions about disclosure of my health information, I can contact the releaser indicated above.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is not required. CFR 164.508. A facsimile or copy of this Authorization shall have the same force as an original.

I have read the above and authorize the disclosure of the protected health information as stated.

Patient Name [Please Print]

Patient Signature

Social Security Number

Date

IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

PLAINTIFF: _____
Name(s)

AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS
Pursuant to 45 CFR 164 (HIPAA)

TO: _____
Name of Entity

Address (Street, City, State, Zip Code)

RE: Plaintiff Name(s): _____ Policy No: _____

Date of Birth: _____ Social Security Number: ____ - ____ - ____

Insured Name(s) (if different): _____

I, _____, hereby authorize you to release and furnish to [Check one or both]:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G) _____;

and/or his/her/their designated agent, **HG Litigation Services**, all my insurance records, including the following:

- All information pertaining to my insurance, including but limited to, all forms and records regarding insurance claims applications and benefits and all medical, health, hospital, physicians, nursing or allied health professional reports, evaluations, records, notes or invoices and bills, which may be in your possession.

I understand that the information in my insurance records may include health information, 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, and treatment for alcohol and drug abuse.

The release of the information listed above is being authorized for purposes of compliance with discovery in the captioned litigation. Any person, firm, or entity that releases information pursuant to this authorization is absolved from any liability that might otherwise result from the release of this information. I understand that I have the right to revoke this authorization at any time by providing to you a written revocation and I agree to simultaneously provide a copy of such revocation to the record requestors identified above. I also understand that any revocation will not apply to information that has

already been released in response to this authorization. *Unless otherwise revoked, this authorization shall be continuing in nature and will expire at the conclusion of my involvement in the captioned litigation.*

I understand that authorizing the disclosure of this insurance information (and any health information contained therein) is voluntary. I can refuse to sign this authorization. I understand that treatment, enrollment, or eligibility for, or payment of, benefits may not be conditioned upon the signing of this authorization. I understand that I may inspect or copy the information to be used or disclosed as provided in 45 CFR 164.524. I understand that the released information may not be protected by federal privacy regulations and may be redisclosed in conjunction with this litigation.

This authorization does not apply to psychotherapy notes, psychiatric or psychological records.

A notarized signature is not required. 45 CFR 164.508. A facsimile, copy or photocopy of this Authorization shall have the same force as an original. This authorization complies with 45 CFR 164 regarding the core elements of an authorization pursuant to HIPAA.

I have read the above and authorize the disclosure of my insurance information (and any health information contained therein) as stated.

Plaintiff Name [Please Print]

Plaintiff Signature

Social Security Number

Date

Policy No. _____

Insured Name (if different) _____

Policy/Group Id No. _____

IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

PLAINTIFF: _____
Name(s)

AUTHORIZATION FOR RELEASE OF EMPLOYMENT/PERSONNEL RECORDS

TO: _____
Name of Entity

Address (Street, City, State, Zip Code)

RE: Plaintiff/Employee Name(s): _____
Date of Birth: _____ Social Security Number: _____-_____-_____

I, _____, hereby authorize you to release and furnish to [Check one or both]:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G) _____;

and/or his/her/their designated agent, **HG Litigation Services**, all my employment and personnel records, other than payroll, W2 or tax records, including the following:

- All information, including but not limited to any and all employment records, personnel records, applications for employment, documents related to the beginning of and termination of employment, employee performance evaluations, vacation and illness benefits and use, reprimand/commendation notices, and all other documents, papers, checks and ledgers showing employee benefits, and the amount of time and number of days worked.

The release of the information listed above is being authorized for purposes of compliance with discovery in the captioned litigation. Any person, firm, or entity that releases information pursuant to this authorization is absolved from any liability that might otherwise result from the release of this information. I understand that I have the right to revoke this authorization at any time by providing to you a written revocation and agree to simultaneously provide a copy of such revocation to the record requestors identified above. I also understand that any revocation will not apply to information that has already been released in response to this authorization. *Unless otherwise revoked, this authorization shall be continuing in nature and will expire at the conclusion of my involvement in the captioned litigation.*

A notarized signature is not required. A facsimile, copy or photocopy of this Authorization shall have the same force as an original.

I have read the above and authorize the disclosure of my employment/personnel information as stated.

Plaintiff/Employee (Please Print)

Signature

Social Security Number

Date

IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

PLAINTIFF: _____
Name(s)

AUTHORIZATION FOR RELEASE OF SCHOLASTIC/EDUCATION RECORDS

TO: _____
Name of Entity

Address (Street, City, State, Zip Code)

RE: Plaintiff Name(s): _____
Date of Birth: _____ Social Security Number: _____ - _____ - _____

I, _____, hereby authorize you to release and furnish to [Check one or both]:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G) _____;

and/or his/her/their designated agent, **HG Litigation Services**, my education and scholastic records, as follows:

- Dates of attendance at your school/institution and any diplomas, certificates or degrees obtained.

The release of the information listed above is being authorized for purposes of compliance with discovery in the captioned litigation. Any person, firm, or entity that releases information pursuant to this authorization is absolved from any liability that might otherwise result from the release of this information. I understand that I have the right to revoke this authorization at any time by providing to you a written revocation and agree to simultaneously provide a copy of such revocation to the record requestors identified above. I also understand that any revocation will not apply to information that has already been released in response to this authorization. *Unless otherwise revoked, this authorization shall be continuing in nature and will expire at the conclusion of my involvement in the captioned litigation.*

A notarized signature is not required. A facsimile, copy or photocopy of this Authorization shall have the same force as an original.

I have read the above and authorize the disclosure of my education and scholastic information as stated.

Plaintiff Name [Please Print]

Signature

Social Security Number

Date

**IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA**

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

THIS DOCUMENT RELATES TO ALL CASES

**Exhibit C to
Case Management Order No. 3**

FROM: Employer:

RE: Employee:

Address:

Address:

S.S.#:

EMPLOYEE AUTHORIZATION

I, _____, do hereby *certify that I received an offer of employment*
Employee Name

from _____ on _____
Employer Name and Address Date

and authorize the **Pennsylvania Bureau of Workers' Compensation** to release all information from Bureau files.

I affirm the information I have provided herein is true. I understand that if I make any false statements which I do not believe to be true and thereby mislead the public servant to whom this request is directed in performing his/her official function, I may be subject to punishment as provided in the Crimes Code, 18 Pa. C.S.A. SS 4904.

Dated: _____

Signed:
Employee

EMPLOYER CERTIFICATION

I, _____, _____ an
Name Title with Employer
employee of and acting as agent for _____, do hereby certify
Employer

that _____ *has extended an offer of employment* to
Employer

_____ on _____ and, I agree that information
Employee Name Date

requested from the **Pennsylvania Bureau of Workers' Compensation** with regard to

_____ will be used by _____ in
Employee Name Employer

conformance with both the Americans with Disabilities Act and the Pennsylvania Human Relations Act.

I affirm the information I have provided herein is true. I understand that if I make any false statements which I do not believe to be true and thereby mislead the public servant to whom this request is directed in performing his/her official function, I maybe subject to punishment in the Crime Code, 18 Pa. C.S.A. SS 4904.

Dated: _____

Signature: _____

Title: _____

**IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA**

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

THIS DOCUMENT RELATES TO ALL CASES

**Exhibit D to
Case Management Order No. 3**

**Social Security Administration
Consent for Release of Information**

Please read these instructions carefully before completing this form.

**When to Use
This Form** **Complete this form only if you want the Social Security Administration to give information or records about you to an individual or group (for example, a doctor or an insurance company).**

Natural or adoptive parents or a legal guardian, acting on behalf of a minor, who want us to release the minor's:

- ' **nonmedical** records, should use this form.
- ' medical records, should not use this form, but should contact us.

Note: Do not use this form to request information about your earnings or employment history. To do this, complete Form SSA-7050-F4. You can get this form at any Social Security office.

**How to
Complete
This Form** **This consent form must be completed and signed only by:**

- ' the person to whom the information or record applies, or
- ' the parent or legal guardian of a minor to whom the **nonmedical** information applies, or
- ' the legal guardian of a legally incompetent adult to whom the information applies.

- To complete this form:**
- ' Fill in the name, date of birth, and Social Security Number of the person to whom the information applies.
 - ' Fill in the name and address of the individual or group to which we will send the information.
 - ' Fill in the reason you are requesting the information.
 - ' Check the type(s) of information you want us to release.
 - ' Sign and date the form. If you are not the person whose record we will release, please state your relationship to that person.

PRIVACY ACT NOTICE: The Privacy Act Notice requires us to notify you that we are authorized to collect this information by section 3 of the Privacy Act. You do not have to provide the information requested. However, we cannot release information or records about you to another person or organization without your consent for release of information. Your records are confidential. We will release only records that you authorize, and only to persons or organizations who you authorize to receive that information.

PAPERWORK REDUCTION ACT STATEMENT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** The office is listed under **U.S. Government agencies in your telephone directory** or you may call Social Security at 1-800-772-1213. *You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 212345-6401. Send only comments relating to our time estimate to this address, not the completed form.*

Social Security Administration
Consent for Release of Information

TO: Social Security Administration

Name Date of Birth Social Security Number

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
_____	_____
_____	_____
_____	_____

I want this information released because:

(There may be a charge for releasing information.)

Please release the following information:

- Social Security Number
- Identifying information (includes date and place of birth, parents' names)
- Monthly Social Security benefit amount
- Monthly Supplemental Security Income payment amount
- Information about benefits/payments I received from _____ to _____
- Information about my Medicare claim/coverage from _____ to _____
(specify) _____
- Medical records
- Record(s) from my file (specify) Entire file is requested
- _____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if a minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____
(Show signatures, names, and addresses of two people if signed by mark.)
Date: _____ Relationship: _____

**IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA**

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

THIS DOCUMENT RELATES TO ALL CASES

**Exhibit E to
Case Management Order No. 3**

IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

PLAINTIFF: _____
Name(s)

AUTHORIZATION FOR RELEASE OF PAYROLL RECORDS

TO: _____
Name of Entity

Address (Street, City, State, Zip Code)

RE: Plaintiff/Employee Name(s): _____
Date of Birth: _____ Social Security Number: _____ - _____ - _____

I, _____, hereby authorize you to release and furnish to [Check one or both]:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G) _____;

and/or his/her/their designated agent, **HG Litigation Services**, all my payroll records, including the following:

- All information, including but not limited to any and all payroll records, W2s and other tax records, and all other documents, papers, checks and ledgers showing wages, salaries, and other earnings or benefits received.

The release of the information listed above is being authorized for purposes of compliance with discovery in the captioned litigation. Any person, firm, or entity that releases information pursuant to this authorization is absolved from any liability that might otherwise result from the release of this information. I understand that I have the right to revoke this authorization at any time by providing to you a written revocation and agree to simultaneously provide a copy of such revocation to the record requestors identified above. I also understand that any revocation will not apply to information that has already been released in response to this authorization. *Unless otherwise revoked, this authorization shall be continuing in nature and will expire at the conclusion of my involvement in the captioned litigation.*

A notarized signature is not required. A facsimile, copy or photocopy of this Authorization shall have the same force as an original.

I have read the above and authorize the disclosure of my payroll information as stated.

Plaintiff/Employee [Please Print]

Signature

Social Security Number

Date

IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

THIS DOCUMENT RELATES TO ALL CASES

**Exhibit F to
Case Management Order No. 3**

Request for Copy of Tax Return

- ▶ Do not sign this form unless all applicable lines have been completed. Read the instructions on page 2.
- ▶ Request may be rejected if the form is incomplete, illegible, or any required line was blank at the time of signature.

Tip: You may be able to get your tax return or return information from other sources. If you had your tax return completed by a paid preparer, they should be able to provide you a copy of the return. The IRS can provide a **Tax Return Transcript** for many returns free of charge. The transcript provides most of the line entries from the tax return and usually contains the information that a third party (such as a mortgage company) requires. See **Form 4506-T**, Request for Transcript of Tax Return, or you can call 1-800-829-1040 to order a transcript.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return	2b Second social security number if joint tax return
3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code	
4 Previous address shown on the last return filed if different from line 3	
5 If the tax return is to be mailed to a third party (such as a mortgage company), enter the third party's name, address, and telephone number. The IRS has no control over what the third party does with the tax return.	

Caution: If a third party requires you to complete Form 4506, do not sign Form 4506 if lines 6 and 7 are blank.

6 Tax return requested (Form 1040, 1120, 941, etc.) and all attachments as originally submitted to the IRS, including Form(s) W-2, schedules, or amended returns. Copies of Forms 1040, 1040A, and 1040EZ are generally available for 7 years from filing before they are destroyed by law. Other returns may be available for a longer period of time. Enter only one return number. If you need more than one type of return, you must complete another Form 4506. **Note:** If the copies must be certified for court or administrative proceedings, check here.

7 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than eight years or periods, you must attach another Form 4506.

/ /	/ /	/ /	/ /
/ /	/ /	/ /	/ /

8 Fee. There is a \$39 fee for each return requested. Full payment must be included with your request or it will be rejected. Make your check or money order payable to "United States Treasury." Enter your SSN or EIN and "Form 4506 request" on your check or money order.

a Cost for each return	\$ 39.00
b Number of returns requested on line 7	
c Total cost. Multiply line 8a by line 8b	\$

9 If we cannot find the tax return, we will refund the fee. If the refund should go to the third party listed on line 5, check here

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax return requested. If the request applies to a joint return, either husband or wife must sign. If signed by a corporate officer, partner, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506 on behalf of the taxpayer.

Sign Here	Signature (see instructions)	Date	Telephone number of taxpayer on line 1a or 2a ()
	Title (if line 1a above is a corporation, partnership, estate, or trust)		
	Spouse's signature	Date	

**IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA**

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

THIS DOCUMENT RELATES TO ALL CASES

**Exhibit G to
Case Management Order No. 3**

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information

Includes periods of employment or self-employment and the names and addresses of employers.

OR

2. Certified Yearly Totals of Earnings

Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM FOR:

Non-certified yearly totals of earnings

This service is free to the public.

These totals can be obtained by calling 1-800-772-1213 to receive Form SSA-7004, Request for Earnings and Benefit Estimate Statement.

PRIVACY ACT NOTICE: We are authorized to collect this information under section 205 of the Social Security Act, and the Federal Records Act of 1950 (64 Stat. 583). It is needed so we can identify your records and prepare the statement you request. You do not have to furnish the information, but failure to do so may prevent your request from being processed.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 11 minutes to read the instructions, gather the necessary facts, and answer the questions.

INFORMATION ABOUT YOUR REQUEST

• How Do I Get This Information?

You need to complete the attached form to tell us what information you want.

• Can I Get This Information For Someone Else?

Yes, if you have their written permission. For more information, see page 3.

• Who Can Sign On Behalf Of The Individual?

The parent of a minor child, or the legal guardian of an individual who has been declared legally incompetent, may sign if he/she is acting on behalf of the individual.

• Is There A Fee For This Information?

1. Certified/Non-Certified Detailed Earnings Information

Yes, we usually charge a fee for detailed information. In most cases, this information is used for purposes NOT directly related to Social Security such as for a private pension plan or personal injury suit. The fee chart on page 3 gives the amount of the charge.

Sometimes, there is no charge for detailed information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us

and it does not agree with your records), we will supply you with more detail for the period in question. Occasionally, earnings amounts are wrong because an employer did not correctly report earnings or earnings are credited to the wrong person. In situations like these, we will send you detailed information, at no charge, so we can correct your record.

Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

We will certify the detailed earnings information for an additional fee of \$15.00. Certification is usually not necessary unless you plan to use the information in court.

2. Certified Yearly Total of Earnings

Yes, there is a fee of \$15 to certify yearly totals of earnings. Certification is usually not necessary unless you plan to use the information in court.

3. Method of Payment

Enclose a check or money order for the entire fee required. Payment can also be made by credit card. To do so, complete page 4 of this form and return it with your request form.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. From whose record do you need the earnings information?

Print the Name, Social Security Number (SSN), and date of birth below.

Name _____ Social Security Number _____
Other Name(s) Used _____ Date of Birth _____
(Include Maiden Name) _____ (Mo/Day/Yr) _____

2. What kind of information do you need?

Detailed Earnings Information For the period(s)/year(s): _____
(If you check this block, tell us below why you need this information.)

Certified Total Earnings For Each Year. For the year(s): _____
(Check this box only if you want the information certified. Otherwise, call 1-800-772-1213 to request Form SSA-7004, Request for Earnings and Benefit Estimate Statement)

3. If you owe us a fee for this detailed earnings information, enter the amount due using the chart on page 3 A. \$ _____

Do you want us to certify the information? Yes No
If yes, enter \$15.00 B. \$ _____

ADD the amounts on lines A and B, and enter the TOTAL amount C. \$ _____

- You can pay by CREDIT CARD by completing and returning the form on page 4, or
- Send your CHECK or MONEY ORDER for the amount on line C with the request and make check or money order payable to "Social Security Administration"
- DO NOT SEND CASH.

4. I am the individual to whom the record pertains (or a person who is authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than \$5,000 or one year in prison.

SIGN your name here (Do not print) > _____ Date _____

Daytime Phone Number _____
(Area Code) (Telephone Number)

5. Tell us where you want the information sent. (Please print)

Name _____ Address _____
City, State & Zip Code _____

6. Mail Completed Form(s) To: **Exception: If using private contractor (e.g., FedEx) to mail form(s), use:**

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

How Much Do I Have to Pay For Detailed Earnings?

1. Count the number of years for which you need detailed earnings information. Be sure to add in both the first and last year requested. However, do not add in the current calendar year since this information is not yet available.
2. Use the chart below to determine the correct fee.

Number of Years Requested	Fee	Number of Years Requested	Fee	Number of Years Requested	Fee
1	\$15.00	15	\$43.75	28	\$64.50
2	17.50	16	45.50	29	66.00
3	20.00	17	47.25	30	67.50
4	22.50	18	49.00	31	68.75
5	25.00	19	50.75	32	70.00
6	27.00	20	52.50	33	71.25
7	29.00	21	54.00	34	72.50
8	31.00	22	55.50	35	73.75
9	33.00	23	57.00	36	75.00
10	35.00	24	58.50	37	76.25
11	36.75	25	60.00	38	77.50
12	38.50	26	61.50	39	78.75
13	40.25	27	63.00	40	80.00
14	42.00				

For Requests Over 40 Years, Please Add 1 Dollar for Each Additional Year.

• **Whose Earnings Can Be Requested**

1. Your Earnings

You can request earnings information from your own record by completing the attached form; we need your handwritten signature. If you sign with an "X", your mark must be witnessed by two disinterested persons who must sign their name and address.

2. Someone Else's Earnings

You can request earnings information from the record of someone else if that person tells us in writing to give the information to you. This writing or "authorization" must be presented to us within 60 days of the date it was signed by that person.

3. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are the legal representative of the estate, a survivor (that is, the spouse, parent, child, divorced spouse of divorced parent), or an individual with a material interest (example-financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

Proof of death must be included with your request. Proof of appointment as representative or proof of your relationship to the deceased must also be included.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit care rules will apply. You may also pay by check or money order.



We Only Accept MasterCard and Visa



Please fill in all the information below and return this form along with your request to:

Social Security Administration
Division of Earnings Record Operations
P.O. Box 33003
Baltimore Maryland 21290-3003

Exception:

If using private contractor (e.g., FedEx) to mail form(s), use:

Social Security Administration
Division of Earnings Record Operations
300 N. Greene St.
Baltimore Maryland 21290-0300

Note: Please read Paperwork/Privacy Act Notice

NUMBER HOLDER'S SSN → <i>(If more than one request, only list one SSN)</i>	_____
CHECK ONE →	<input type="checkbox"/> MasterCard <input type="checkbox"/> VISA
Credit Card Holder's Name → (Enter the name from the credit card)	First, Middle Initial, Last Name
Credit Card Holder's Address →	Number & Street City, State, Zip Code
Daytime Telephone Number →	_____ <small>Area Code Telephone Number</small>
Amount Charged \$ _____	Credit Card Number _____
Credit Card Holder's Signature →	Credit Card Expiration Date Month _____ Year _____
DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization Name _____ Date _____

PRIVACY ACT NOTICE

The Social Security Administration (SSA) has authority to collect the information requested on this form under section 205 of the Social Security Act. Giving us this information is voluntary. You do not have to do it. We will need this information only if you choose to make payment by credit card. You do not need to fill out this form if you choose another means of payment (for example, by check or money order).

If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and SSA's account. We may also provide this information to another person or government agency to comply with federal laws requiring the release of information from our records. You can find these and other routine uses of information provided to SSA listed in the Federal Register. If you want more information about this, you may call or write any Social Security Office.

IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

THIS DOCUMENT RELATES TO ALL CASES

**Exhibit H to
Case Management Order No. 3**

IN THE COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA

IN RE: DENTURE ADHESIVE CREAM

JUNE TERM, 2009

MASS TORT PROGRAM

NO: 4534

PLAINTIFF: _____
Name(s)

**AUTHORIZATION FOR THE RELEASE OF MENTAL HEALTH RECORDS
PURSUANT TO 45 CFR 164.508(a)(2) (HIPAA)**

TO: _____
Name of Mental Healthcare Provider/Physician/Facility

Address (Street, City, State, Zip Code)

RE: Patient Name: _____
Date of Birth: _____ Social Security Number: _____
Address: _____

I, _____, hereby authorize you to release and furnish to [Check one or both]:

Stephanie A. Smith, Fulbright & Jaworski LLP (GSK) _____;
Frank C. Woodside III, Dinsmore & Shohl LLP (P&G) _____;

and/or her/his/their designated agent, **HG Litigation Services**, copies of full and complete protected medical and mental health information, including the following:

For use in the In Re: Denture Adhesive Cream Litigation, June Term 2009, No. 4534. To my healthcare provider: This authorization is forwarded by attorneys for defendant(s). This authorization permits you to release copies of records you made in connection with examinations, diagnosis and treatment of me; it does not permit you, nor does it authorize you, to speak to anyone concerning your care and treatment of me, unless you receive a separate and additional authorization permitting such discussion. Subject to all applicable legal objections, this restriction does not apply to discussing my medical history, care, treatment, diagnosis, prognosis, information revealed by or in the records, or any other matter bearing on my medical or physical condition at a deposition or trial.

- All psychiatric, psychological or other confidential records relating to my emotional or other psychiatric/psychological condition for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated records custodian of all covered entities under HIPAA identified above disclose full and complete protected medical and mental information including the following:

- All psychiatric/psychological records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, records received by other physicians, pharmacy and prescription records, billing records and records of billing to third party payers and payment or denial of benefits.

This protected health information is disclosed for the following purposes: The currently pending litigation involving the person named above.

This authorization is given in compliance with 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release the above records to the representatives of defendants noted above who have agreed to pay reasonable charges made by you to supply copies of such records.

I acknowledge that I have the right to revoke this authorization by written notification to you at the above referenced address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer be protected under 45 CFR 164.508.

I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

I understand that the nature of this authorization is to authorize the release of my mental health records.

A notarized signature is not required. CFR 164.508. A facsimile, copy or photocopy of this Authorization shall have the same force as an original. *Unless otherwise revoked, this authorization shall expire at the conclusion of my involvement in the captioned litigation.*

I have read the above and authorize the disclosure of the protected mental health information as stated.

Patient Name [Please Print]

Patient Signature

Social Security Number

Date