

PROOF OF CLAIM

**** A SEPARATE FORM MUST BE COMPLETED FOR EACH CLAIMANT****

NOTICE: The form you are about to complete, including the Schedules, are legal documents and are provided to you for purposes of making your claim or a claim for any person who is a minor, a deceased person, or an incompetent person, or for any other person for whom you are acting as a legal representative. Your failure to answer truthfully could lead to all or a portion of your claim being denied and/or criminal sanctions for perjury.

Completing a Proof of Claim does not mean you are entitled to payment of any money from the Class Settlement Funds. The Court shall determine in accordance with the protocol to be established the entitlement, if any, of each Claimant to payment from the Class Settlement Funds and the appropriate amount of such payment.

SECTION I - GENERAL INFORMATION:

Name: _____

Are you the claimant? Yes No

If **YES**, go to Section II, Claimant Information.

If **NO**, continue here.

Name of Representative: _____
(Last, First & Middle)

Representative is: Parent Guardian Tutor/Tutrix Curator
 Power of Attorney Other _____

Please attach a copy of official document that allows you to act as the legal representative of the Claimant.

Is represented person deceased? Yes No

If YES, Date of Death: _____

SECTION II - CLAIMANT INFORMATION:

Claimant's Name: _____

Any other names used: _____

Claimant's date of birth: _____ Place of Birth: _____

Claimant's Sex: _____

Claimant's Driver's License No: _____ State _____

Claimant's Social Security No.: _____

Are you a citizen of the United States? _____ Yes _____ No

Claimant's current mailing address: _____

Claimant's current residence address: _____

Other addresses at which claimant has lived within last 30 years: (SEE Schedule A)

Day Telephone No: _____ Night Telephone No: _____

Name, Address and Phone Number of nearest relative not living at Claimant's address:

Name: _____

Address: _____

City, State, Zip _____

Day Number: _____

Is the Claimant represented by an attorney? _____ Yes _____ No

If YES, complete the following:

Attorney's Name: _____

Telephone Number _____

Address: _____

Had Claimant ever been located (living, working, visiting, hunting, fishing, camping, etc.) within a 5 mile radius of the Bayou Sorrel Injection Well at any time prior to May 20, 2008?

_____ Yes _____ No

If the answer to the preceding question is YES, was the time the Claimant was so located between January 1, 1976, and November 3, 2004?

_____ Yes _____ No

If the answer to the preceding question is YES, did Claimant file an opt-out form in the *In re Bayou Sorrel Litigation*, suit number 04-1101 in the United States District Court for the Western District of Louisiana?

_____ Yes _____ No

If **YES**, provide a copy of your opt out form.

If **NO**, then STOP HERE. Claimant is not eligible for award in this matter

Has Claimant ever made any claim for damages for any personal injury and/or property damage in any lawsuit?

_____ Yes _____ No

If yes, complete **Schedule B**

Has Claimant ever chewed, smoked, consumed, or used tobacco products?

_____ Yes _____ No

If yes, complete **Schedule C**

Has Claimant ever claimed to have been disabled or diagnosed or declared disabled for any reason?

_____ Yes _____ No

If YES,

Date: _____ Name of entity: _____

Has Claimant ever been employed? _____ Yes _____ No

If yes, complete **Schedule D**

Claimant's detailed medical history: **Complete Schedule E**

Did Claimant sustain property damage as a result of the operation of the Injection Well?

_____ Yes _____ No

If YES, complete **Schedule F**

Did Claimant suffer any injury, illness, disease, condition or symptom as a result of the operation of the Injection Well?

_____ Yes _____ No

If YES, complete **Schedule G**

Has Claimant received money from any source (including insurance companies) or signed any releases in connection with damages sustained as a result of operation of the Injection Well?

_____ Yes _____ No

If YES, specify:

From whom: _____

Amount: _____

Why was money received? _____

Was a Release signed? _____ Yes _____ No

If YES, identify who was released and attach a copy of any Release that was signed:

SCHEDULE A - RESIDENCE INFORMATION

List each and every location (municipal address, city, state, and zip code) you have lived since 1976 and the period of time you lived at each location.

_____ (Municipal Address)
_____ (City, State, Zip Code)
_____ (Period of Time)

___ Own ___ Rent

Did anyone disclose to you that there was a potential environmental hazard associated with the property when you purchased, rented or leased the property?

_____ Yes ___ No

If YES, please explain:

Did you disclose to anyone that there was a potential environmental hazard associated with the property when you sold the property?

_____ Yes ___ No

If YES, please explain:

ATTACH ADDITIONAL PAGES FOR EACH ADDITIONAL RESIDENCE, IF NECESSARY, RESPONDING TO EACH SUB-PART ABOVE FOR EACH ADDITIONAL RESIDENCE.

**SCHEDULE B - PERSONAL INJURY OR PROPERTY DAMAGE
APART FROM THIS MATTER**

Please provide the following information if you have filed any lawsuit or claim for personal injury or property damage IN ANY PROCEEDING OTHER THAN THIS CASE:

- A. Name of the case or proceeding _____
- B. Name of the court or administrative agency _____
- C. Case number _____
- D. Date the suit or claim was filed _____
- E. Description of claim(s) made by you:
- F. Name of attorney representing you _____
- G. Address of attorney _____

- H. Status or result of suit or claim: _____

**ATTACH ADDITIONAL PAGES FOR EACH ADDITIONAL LAWSUIT OR CLAIM,
RESPONDING TO SUB-PARTS A THROUGH AND INCLUDING H FOR EACH
ADDITIONAL LAWSUIT OR CLAIM.**

SCHEDULE C - TOBACCO PRODUCTS USED

Type:

_____cigarettes_____chew tobacco _____pipe _____cigars _____other_____

_____Brand _____filtered _____non-filtered

Age began _____

Age stopped _____

Why did you stop _____

How often do you or did you use/consume tobacco: _____

SCHEDULE D - EMPLOYMENT

Beginning with your MOST RECENT employment, provide the following:

- A. Name and address of most recent employer: _____

- B. Dates of employment (month\year to month\year): _____ to _____

- C. Average number of hours worked per week: _____

- D. What type of business: _____

- E. Describe your position and describe the duties you performed: _____

F. Your hourly rate of pay or monthly salary: _____

H. Name and address of prior employer: _____

I. Dates of employment (month\year to month\year): _____ to _____

J. Average number of hours worked per week: _____

K. What type of business: _____

L. Describe your position and describe the duties you performed: _____

M. Your hourly rate of pay or monthly salary: _____

N. Name and address of prior employer: _____

O. Dates of employment (month\year to month\year): _____ to _____

P. Average number of hours worked per week: _____

Q. What type of business: _____

R. Describe your position and describe the duties you performed: _____

S. Your hourly rate of pay or monthly salary: _____

ATTACH ADDITIONAL PAGES, IF NECESSARY, RESPONDING TO EACH SUB-PART FOR EACH ADDITIONAL EMPLOYER, RESPONDING TO SUB-PARTS A THROUGH AND INCLUDING E FOR EACH ADDITIONAL EMPLOYER.

T. Have you ever worked with and/or were you ever exposed to any chemical or toxic and/or cancer-causing substances and/or materials?

_____ Yes _____ No

If YES, identify each chemical, substance or material that you worked with and/or to which you were exposed, including the dates of such work and/or exposure:

U. Were you ever required to wear and/or utilize protective clothing or equipment?

_____ Yes _____ No

If YES, please identify each type of protective clothing and equipment

V. Were you ever required to take part in a health monitoring or health screening program?

Yes No

If YES, please identify the monitoring or screening program: _____

W. Did you ever participate in a pre-employment or other employment related physical examination?

Yes No

If YES, please identify the date(s), name and address of the physician conducting the physical examination: _____

X. Have you ever lost wages from any job as a result of any illness you claim was caused by the operations at the Injection Well?

Yes No

If YES, what illness: _____

Amount of wages you claim to have lost: _____

Y. Have you ever lost wages from any job as a result of any illness you claim was related to your occupation?

Yes No

If YES, what illness: _____

Amount of wages you claim to have lost: _____

SCHEDULE E - MEDICAL HISTORY

Please identify in detail your medical history including, but not limited to, the name(s) and address(es) of all physicians, psychiatrists, psychologists, and/or health care providers with whom you have ever consulted, as well as any hospital and/or other health care facility in which you have been treated and/or admitted, the dates on which said treatment was rendered and the name and the address of each physician and/or other health care provider who attended you at each hospital and/or other health care facility. You must also sign authorizations for release of medical records and/or psychiatric/mental health records.

Describe Each Illness or Injury: _____

1. Treatment Information History:

Treatment Received: _____

Treatment Date(s): _____

Health Care Provider(s): _____

Address(es): _____

City, State, Zip _____

Hospital Name(s): _____

Address(es): _____

City, State, Zip _____

1. Treatment Information History:

Treatment Received: _____

Treatment Date(s): _____

Health Care Provider(s): _____

Address(es): _____

City, State, Zip _____

Hospital Name(s): _____

Address(es): _____

City, State, Zip _____

Do you allege these medical problems to be related to the operation of the Injection Well:

_____ Yes _____ No

If YES:

When did you first became aware of each such medical problem? _____

Date this medical problem was diagnosed by a physician? _____

Physician who first diagnosed this medical problem? _____

Address: _____

City, State, Zip _____

Total charges you paid for treatment of this medical problem:\$ _____

List all medication (including over the counter medicines) prescribed to you for this medical problem and the pharmacy at which you purchased the medication:

Medication(s): _____

Pharmacy(ies): _____

Amount paid by you: _____

SCHEDULE F – PROPERTY DAMAGE CLAIMS

Please identify all of your property damage you claim to have sustained damage as a result of the operation of the Injection Well:

Type of Property Damaged: _____ Home _____ Land

Address of Property Damaged: _____

Are you the owner of the damaged property?

_____ Yes _____ No

If YES, provide proof of ownership.

Type of Damage: _____

Have you had any chemical analyses, testing and/or monitoring performed for the damaged property?

_____ Yes _____ No

If YES, provide copies of all results of analyses, testing and/or monitoring.

Have you received any estimates establishing the amount of damages to the property?

_____ Yes _____ No

If YES, provide copies of all estimates.

SCHEDULE G – PERSONAL INJURY OR ILLNESS DAMAGE CLAIMS

Please identify each personal injury, illness or disease you claim to have sustained damage as a result of the operation of the Injection Well: _____

When did you first became aware of each injury/illness/disease described above? _____

Date each such injury/illness/disease problem was first treated by a physician?

Date each such injury/illness/disease was diagnosed by a physician as being caused by operations at the injection well? _____

Physician(s) who first diagnosed each such injury/illness/disease?

Address: _____

City, State, Zip _____

Total charges you paid for treatment of each medical problem: \$ _____

List all medication (including over the counter medicines) prescribed to you for each such medical problem and the pharmacy(ies) at which you purchased the medication:

Medication(s): _____

Pharmacy(ies): _____

Amount paid by you: _____

VERIFICATION

STATE OF LOUISIANA

PARISH OF _____

BEFORE ME, the undersigned authority, personally came and appeared:

who, after being duly sworn, did attest and declare the following:

That he/she is the Claimant or representative of the Claimant in the attached Proof of Claim and Schedules attached thereto.

That Claimant understands that said information is given under oath and is part of the Claims Process being undertaken in connection with the matter titled *Walter Allen, et al. versus Rollins Environmental Services (LA), Inc., et al.*, Adversary Proceeding Number 07-01134 pending in the United States Bankruptcy Court for the Middle District of Louisiana.

That under penalty of perjury the undersigned Claimant states that all responses and answers set forth in the Proof of Claim and Schedules attached thereto are true and correct to the best of the Claimant's knowledge, information, and belief.

Claimant Signature

Date Signed

Sworn to and subscribed before me, this _____ day of _____, 2008.

Notary Public
Print Name: _____
LA. Bar No. (or) LA. Notary Public No.

Claimant's Name: _____
Claimant's S.S. No.: _____
Claimant's Date of Birth: _____
Claimant's File No.: _____