

*Must Be Postmarked
On or Before
MARCH 14, 2008*

**ZOLADEX® SETTLEMENT
CLAIM FORM**

If you would like to submit a claim in the Settlement, complete this form and mail it to the address below, along with proof of payment for Zoladex® (see Section E below). You may be asked for more information at a later time.

SECTION A: CLAIMANT INFORMATION (Please print or type)

Please check the box if name and address are different from information on left and complete Section B below.

Please indicate whether you are claiming on your own behalf as a Class Member or on behalf of someone else who is a Class Member:

- ___ I am a Class Member
- ___ I am the spouse of a deceased Class Member
- ___ I am the legal representative of a deceased Class Member's estate

SECTION B: CONTACT INFORMATION (Please print or type)

Class Member's Name

Class Member's Birth Date

Applicant Name (if different from pre-printed name in Section A above)

Street Address

Apartment

City

State

Zip Code

Daytime Telephone Number: (_____) _____

SECTION E: PROOF OF PAYMENT

As part of your claim, you **must** provide proof that you made a percentage co-payment for Zoladex® under Medicare Part B.

Any of the following are acceptable as proof of a percentage co-payment for Zoladex®:

- (1) A receipt, cancelled check, or credit card statement that shows a payment for Zoladex® (other than a flat co-payment); or
- (2) A letter from a doctor saying that he or she prescribed Zoladex® and you paid part of the cost of Zoladex® (other than a flat co-payment) at least once; or
- (3) A statement signed by you under penalty of perjury in the form supplied (see Section F below) that you paid a percentage co-payment for Zoladex® during the period from January 1, 1991 through December 31, 2004; or
- (4) Any of the above executed by a spouse of a deceased class member or a legal representative of the deceased class member's estate.

If, **after** receiving this Notice, you make a percentage co-payment for Zoladex® under Medicare Part B based on a bill that you received from a doctor or clinic related to taking Zoladex® from January 1, 1991 through December 31, 2004, you may submit a claim but **must** submit a receipt, cancelled check, or credit card statement evidencing the payment and proof that the payment was for Zoladex® taken between January 1, 1991 and December 31, 2004 in order to be eligible to participate in the Settlement.

SECTION F: SWORN STATEMENT REGARDING PAYMENTS MADE

I declare under penalty of perjury that the information provided here is, to the best of my knowledge, correct. I also declare under penalty of perjury that I paid a percentage co-payment for Zoladex® at some time during the period from January 1, 1991 through December 31, 2004. If not submitting this for myself, I am authorized to submit this form on behalf of the Class Member identified above because I am the spouse of a deceased Class Member or the legal representative of a deceased Class Member's estate.¹

Signature

Date

Your Claim Form should be mailed to:

AstraZeneca AWP Settlement Administrator
c/o Complete Claim Solutions, LLC
P.O. Box 24787
West Palm Beach, FL 33416
Toll-Free Telephone: 877-625-9451
www.AstraZenecaAWPSettlement.com

¹ Please note that your signature on this Claim Form indicates that you declare, under penalty of perjury, that you (or someone on whose behalf you are acting) made a percentage co-payment for Zoladex® at some time during the Class Period. As a result, providing false information on this Claim Form could constitute perjury.