NAS CLAIM FORM
FOR PURDUE NAS PI TRUST DISTRIBUTION PROCEDURES

Eligibility and Claim Requirements:

In order to be eligible for a Distribution[1] from the Purdue PI Trust (the "**PI Trust**") for a NAS PI Channeled Claim, a claimant will, among other things, be required to:

a) Hold a NAS PI Channeled Claim against one or more Debtors;

b) Have timely filed individual personal injury Proof of Claim for such NAS PI Channeled Claim against one or more Debtors in the Chapter 11 Cases;

c) Submit the required proof demonstrating a diagnosis by a licensed medical provider of a medical, physical, cognitive or emotional condition resulting from the NAS Child's intrauterine exposure to opioids or opioid replacement or treatment medication, including but not limited to the condition known as neonatal abstinence syndrome ("**NAS**").

Important Note: If you provided the required documentation in connection with (i) the *Mallinckrodt plc* (Case No. 20-12522) (Bankr. D. Del.) bankruptcy, (ii) the *Endo International plc* (Case No. 22-22549) (Bankr. S.D.N.Y.) bankruptcy, or (iii) your Proof of Claim that was filed in the Debtors' Chapter 11 Cases, you do not need to resubmit the required documentation, but shall provide the PI Claims Administrator with a statement (or if filing in bulk by the Firm, with a list) confirming the previously filed Claim(s) for the PI Claims Administrator to review;

Additionally, each Holder of a NAS PI Claim seeking an Award from the PI Trust must complete, sign, and submit the following documents so that they are **received on or before July 28, 2025** ("**Claims Deadline**"):[2]

a) This NAS PI Claim Form (the "**NAS Claim Form**");

b) The applicable HIPAA consent form found on pages 13 and 14 of this NAS Claim Form;

c) To the extent the NAS PI Channeled Claim concerns the injuries of a decedent of the Holder of such Claim, the Heirship Declaration, which can be found on the Purdue PI Trust website at purduepitrust.com, or valid estate documents authorizing the Holder of the Claim to act on behalf of the decedent's estate; and

d) For Holders of NAS PI Claims that are minors, a Proxy Form found on pages 10 through 12 of this NAS Claim Form, which can also be found in Exhibit D of the NAS PI TDP.

---

[1] Capitalized terms used but not defined herein have the meanings ascribed to them in the NAS Personal Injury Trust Distribution Procedures ("**NAS PI TDP**") or, if not defined therein, then the meanings ascribed to them in the Thirteenth Amended Joint Chapter 11 Plan of Reorganization of Purdue Pharma L.P. and Its Affiliated Debtors (the "**Plan**"). The most recent versions of the NAS PI TDP and the Plan can be found at http://www.purduepitrust.com.

[2] Parties that previously filed claims and provided the required documentation in connection with (i) the Mallinckrodt plc (Case No. 20-12522) (Bankr. D. Del.) bankruptcy, ((ii) the Endo International plc (Case No. 22-22549) (Bankr. S.D.N.Y.) bankruptcy, or (iii) your Proof of Claim that was filed in the Debtors' Chapter 11 Cases do not need to provide further documentation, except as set forth herein. In the event of law firms with a large inventory doing bulk uploads, the PI Trustee shall establish procedures for bulk attestations.

FAILURE TO TIMELY SUBMIT THIS NAS CLAIM FORM ALONG WITH THE REQUIRED INFORMATION OUTLINED UNDER THE ELIGIBILITY SECTION ABOVE BY JULY 28, 2025, IN ACCORDANCE WITH THE NAS PI TDP MAY RESULT IN THE NAS PI CLAIM BEING DEEMED A DISPUTED CLAIM THAT WILL BE THE SUBJECT OF AN OBJECTION.

THE NAS PI TDP AND ANY FORMS REFERENCED IN THIS NAS CLAIM FORM CAN BE FOUND ON THE PI TRUST WEBSITE AT HTTP://WWW.PURDUEPITRUST.COM.[3]

Instructions for NAS Claim Form Submission:

If you represent the interests of an NAS Child and are seeking to recover money from the PI Trust on account of that NAS Child's NAS PI Channeled Claim(s), you must complete this NAS Claim Form and return the form as instructed below. If you do not complete the form, you MAY NOT qualify to receive funds on behalf of the NAS PI Claimant you represent, and your NAS PI Claim may be the subject of an objection, disallowance or a denial.

If you believe that the NAS Child you represent holds multiple NAS PI Channeled Claims against the Debtors on account of multiple injuries, you should submit only one NAS Claim Form.

If you represent the interests of more than one NAS Child, you must file a NAS Claim Form on behalf of each individual NAS Child. YOU CANNOT file one NAS Claim Form on behalf of multiple children.

Please follow the instructions of each section carefully to ensure that the NAS Claim Form is submitted correctly. Except as otherwise indicated, all words shall be given their ordinary meaning. Submitting this NAS Claim Form does not guarantee that your NAS PI Claim will be Allowed or that you will receive payment from the PI Trust.

It is the responsibility of the Holder of the NAS PI Claim or its representative to submit this NAS Claim Form along with the Required Information (i.e. the HIPAA Form *AND* Evidence demonstrating a diagnosis by a licensed medical provider or a medical, physical, cognitive, or emotional condition resulting from intrauterine exposure, to either opioids or opioid replacement/treatment medication as outlined in the NAS PI TDP) by the Claims Deadline.

If the NAS PI Claim is filed on behalf of an individual who is a minor, then a Proxy Form and supporting documentation, if required, authorizing the person to act on behalf of the Minor must be submitted as well.

[3] The NAS PI TDP that is currently on the PI Trust Website is substantially complete but will likely have changes. An updated NAS PI TDP will be filed with the Bankruptcy Court as part of the Plan Supplement and will be considered by the Bankruptcy Court for approval at the hearing to consider confirmation of the Debtors' Plan of Reorganization, on a date to be scheduled.

This NAS Claim Form along with the Required Information can be completed and submitted online at https://www.purduepitrust.com or by sending such completed Claim Form and Required Information by:

(i) e-mail to purduepitrust@purduepitrust.com,

(ii) mail to Purdue PI Trust, P.O. Box 361930, Hoover, Alabama, 35236-1930, or

(iii) fax to 205-716-2364.

Law firms representing more than one NAS PI Claimant, should visit the Law Firm Bulk Submittal tab on the https://www.purduepitrust.com website for additional information regarding submittal of claims for multiple, represented NAS PI Claimants.

PLEASE PRINT ALL INFORMATION CLEARLY AS THE INFORMATION PROVIDED WILL BE USED TO BOTH EVALUATE YOUR CLAIM AND CONTACT YOU.

PART ONE: PERSONAL INFORMATION OF NAS PI CLAIMANT AND HIS/HER REPRESENTATIVE

Section 1.A – Fill out the information of the NAS Child below:

NAS Child's Name: _____
First Middle Last

NAS Child's Date of Birth: _____/_____/_____
DD MM YYYY

NAS Child's Date of Death: (if applicable) _____/_____/_____
DD MM YYYY

NAS Child's Current Address:
_____
Street Address
_____
City State Zip

NAS Child's Full Social Security Number: (or Taxpayer ID or Social Insurance Number) _____

Kroll/Prime Clerk Proof of Claim Number(s) in Purdue's Chapter 11 Cases: _____

Section 1.B – Fill out your information below:

Your Name: _____
First Middle Last

Your Date of Birth: _____/_____/_____
DD MM YYYY

Your Address:
_____
Street Address
_____
City State Zip

Section 1.B – Fill out your information below: (continued)

Your Social Security Number: (or Taxpayer ID or Social Insurance Number) _____

Relationship to NAS Child: _____
(Natural/Birth Parent, Adoptive Parent, Legal Guardian, or Other Custodian)

Name of Your Representative: (if applicable) _____
First Middle Last

Legal Authority for Representative: (if applicable) _____
(e.g., Power of Attorney, Legal Guardian, Conservator, etc.)

Address of Representative:

Street Address

City State Zip

PART TWO: MEDICAL PROVIDER INFORMATION

Section 2.A: This section concerns licensed medical providers who have diagnosed the NAS Child with any medical, physical, cognitive or emotional condition resulting from his/her intrauterine exposure to opioids or opioid replacement or treatment medication(s). The diagnoses may include, but are not limited to, the condition known as neonatal abstinence syndrome ("**NAS**"). Fill out and provide the following information, if known:

Name of Licensed Medical Provider	Address	City	State	Zip	Date of Diagnosis

PART TWO: MEDICAL PROVIDER INFORMATION (CONTINUED)

Section 2.B: Even if you do not know the information sought in Section 2.A, **please include with your submission of this NAS Claim Form Competent Evidence that a licensed medical provider has diagnosed the NAS PI Claimant with any medical, physical, cognitive or emotional condition resulting from the NAS Child's intrauterine exposure to opioids or opioid replacement or treatment medication(s).** The diagnoses may include, but are not limited to, the condition known as NAS. The diagnosis can be made by any licensed medical professional, specifically including physicians, nurses, physician assistants, mental health counselors or therapists, or professionals at a rehabilitation center. Evidence can include, among other things, medical records evidencing that the NAS Child had a NAS diagnosis, including post-natal treatment for symptoms caused by opioid exposure, symptoms of post-natal withdrawal from opioids, medical scoring for NAS or NOWS which is positive or indicates fetal opioid exposure, a positive toxicology screen of the birth mother or infant for opioids or opioid-weaning drugs, or medical evidence of maternal opioid use.

Section 2.C: Was the NAS Child born in a medical facility? If so:

Name of the Facility where the NAS Child was born: _____

Location (city and state) where NAS Child was born: _____

PART THREE: MEDICAL LIENS

Section 3.A: Did any insurance company pay for medical treatment for the NAS Child's opioid-related injuries? Yes: _____ No:_____

Section 3.B: In the last 20 years, was the NAS Child eligible for coverage by any of the following providers?

Please answer the question above by writing "Yes" or "No" next to each insurance provider name and provide the requested information as to each. If any insurance carrier who provided coverage to the NAS Child is not listed below, please fill in that provider's name and information at the bottom of the chart**.** You may submit the information on additional paper, if needed, in order to provide all of the information requested.

Insurance Provider	Yes or No	Address, Phone & Policy Number	Policy Holder and Dates of Coverage
Medicare		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____

PART THREE: MEDICAL LIENS (CONTINUED)			
Medicaid		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
Tricare		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
VA		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
Champus		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____
Private (1) List insurance provider name below: _____ _____		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____

PART THREE: MEDICAL LIENS (CONTINUED)

Private (2) List insurance provider name below: _____ _____		Address: _____ _____ Phone #: _____ Policy #: _____	Policy Holder Name: _____ Dates of Coverage: _____

PART FOUR: SIGNATURE

This NAS Claim Form must be signed by the Holder of the NAS Claim or its Representative or Counsel of Record.

NAS Child's Name: _____

NAS Child's E-mail (if any): _____

NAS Child's Phone Number (if any): _____

Name of the person signing this Form: _____

E-mail address of the person signing this Form: _____

Phone Number of the person signing this Form: _____

IF SIGNING AS THE NAS PI CLAIMANT OR INDIVIDUAL ACTING ON BEHALF OF THE NAS PI CLAIMANT:

I declare under penalty of perjury that the representations made and the information provided on this NAS Claim Form are true, correct and complete to the best of my knowledge.

_____

Signature of Holder of NAS PI Claim
(or signature of Representative Completing this Form on Behalf of such Holder)

IF SIGNING AS COUNSEL OF RECORD:

I, _____, Counsel for the Holder of the NAS PI Claim or his/her Personal Representative, hereby swear under penalty of perjury that the information contained herein is true and accurate to the best of my knowledge made after conducting due diligence, and that this NAS Claim Form is being filed with the consent of my client, or the authority to file on my client's behalf under applicable law and/or with appropriate power of attorney.

_____

Signature of Counsel of Record to Holder of NAS PI Claim or Its Representative

PART FOUR: SIGNATURE

CONFIRMATION OF SUBMISSION OF REQUIRED PROOF (Please check one):

I am including the required evidence that demonstrates that a licensed medical provider has diagnosed the NAS PI Claimant with any medical, physical, cognitive or emotional condition resulting from the NAS Child's intrauterine exposure to opioids or opioid replacement or treatment medication(s), as required under PART TWO above in my submission of this Claim: **Yes: _____ No: _____**

Did you previously file a NAS PI Claim with the Mallinckrodt plc (Case No. 20-12522) (Bankr. Del.) bankruptcy NAS Personal Injury Trust (the "**MNK NAS PI Trust**") or the Endo International plc (Case No. 22-22549) (Bankr. SDNY) bankruptcy NAS Personal Injury Trust (the "**Endo NAS PI Trust**"), or you previously provided evidence that demonstrates that a licensed medical provider has diagnosed the NAS PI Claimant with any medical, physical, cognitive or emotional condition resulting from the NAS Child's intrauterine exposure to opioids or opioid replacement treatment medication(s) with a Proof of Claim that was filed in the Debtors' Chapter 11 Cases?
Yes: _____ No: _____

If you answered yes above to filing a NAS PI Claim in the MNK NAS PI Trust or the Endo NAS PI Trust, please indicate which one you filed with:

MNK NAS PI Trust **Yes: _____ No: _____**
Endo NAS PI Trust **Yes: _____ No: _____**

REMINDER: Unless as stated above, evidence demonstrating that a licensed medical provider has diagnosed the NAS PI Claimant with any medical, physical, cognitive or emotional condition resulting from the NAS Child's intrauterine exposure to opioids or opioid replacement or treatment medication(s), as outlined in the NAS PI TDP MUST BE SUBMITTED WITH THIS NAS CLAIM FORM by the Claims Deadline. Failure to do so will result in the NAS PI Claim being deficient as outlined in the NAS PI TDP and may be the subject of an objection, disallowance or denial.

PURDUE PROXY FORM NAS MINOR CLAIMANTS

PART ONE: PERSONAL INFORMATION OF NAS CHILD AND THEIR PROXY

NAS Child Information (Fill out the information for the NAS Child)

NAS Child's Name: _____
First Middle Last

NAS Child's Date of Birth: _____/_____/_____
DD MM YYYY

NAS Child's Current Address: _____
Street Address

_____
City State Zip

NAS Child's Full Social Security Number: (or Taxpayer ID or Social Insurance Number) _____

Proxy Information (Fill out this information as the Purported Proxy of the NAS Child, if applicable)

Proxy's Name: _____
First Middle Last

Proxy's Relationship to the Minor Claimant: _____
Custodial Parent (Natural/Birth/Adoptive), Legal Guardian, or Other Custodian

Proxy's Date of Birth: _____/_____/_____
DD MM YYYY

Proxy's Address: _____
Street Address

_____
City State Zip

Proxy's Social Security Number: (or Taxpayer ID or Social Insurance Number) _____

Proxy's Phone Number: _____

PART TWO: PROXY TYPE (you must supply the following evidence to the Trust)

ONLY SELECT ONE: Please **check** the one section that applies to you, **fill out** the information included and **provide** the **required** information and evidence, if applicable

☐

I Am A Custodial Parent

Please **fill out** this section if you are the **custodial parent** of a NAS Child.

I, _____, am the Custodial Parent (biological mother/father with whom the child currently lives) of the NAS Child, _____.

I declare, under penalty of perjury, that the representations made and the information provided on this Proxy form are true, correct, and complete to the best of my knowledge.

Signature of the Purported Proxy acting on behalf of the NAS Child:

_____

Print Name: _____ Date: _____

☐

I Am A Court Appointed Legal Guardian

Please **fill out** this section and **provide the applicable order** if you are the **legal guardian** of a Minor Claimant.

I, _____, have been appointed by the court as the guardian of the NAS Child, _____, and am providing the order appointing me as the legal guardian of the NAS Child.

I declare, under penalty of perjury, that the representations made and the information provided on this Proxy form are true, correct, and complete to the best of my knowledge.

Signature of the Purported Proxy acting on behalf of the NAS Child:

_____

Print Name: _____ Date: _____

☐ **I am providing custody and care for the NAS Child, but I am neither the Custodial Parent nor the Court Appointed Legal Guardian.**

Please **fill out** this section and **provide the applicable statements and/or records** if you are **providing custody and care for the NAS Child but are neither the custodial parent nor the court appointed legal guardian** of the NAS Child.

I, _____, am providing custody and care to the NAS Child, _____.

I have been providing custody and care to the NAS Child since _____ (date).

My relationship with the NAS Child is:

_____

The circumstances around the provisions and care of the NAS Child are:

_____

_____

_____

I am providing the statements and/or records marked below as a form of evidence to the Trust to support my statement under penalty of perjury: **(select one)**

_____ Records/statements from the NAS Child's school or childcare provider

_____ Records/statements from my landlord or property manager

_____ Records/statements from the placement agency which put the NAS Child in my care

_____ Records/statements from a governmental social services agency

_____ Records/statements from Indian tribe officials

_____ Records/statements from my employer

_____ Records/statements from NAS Child's medical/healthcare provider

I declare, under penalty of perjury, that the representations made and the information provided on this Proxy form are true, correct, and complete to the best of my knowledge.

Signature of the Purported Proxy acting on behalf of the NAS Child:

_____

Print Name: _____ Date: _____

HIPAA RELEASE FORM FOR
PURDUE PI TRUST DISTRIBUTION PROCEDURES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Injured Party Name: _____ Date: _____

Injured Party Date of Birth: _____ Soc Sec #: _____

1. The following individuals or organizations are authorized to disclose my health records to the parties specified below in section #4:

_____
_____
_____
_____
_____

(Note: Please list the names of your medical care providers and your health insurance providers that may have records relevant to the resolution of your NAS PI Claim. If you are unsure of the exact legal name of your medical providers and health insurance providers, you can leave this blank, and we will complete it for you with the understanding that you authorize all relevant parties):

2. The type and amount of information to be used or disclosed is as follows:

The entire record, including but not limited to: any and all medical records, mental health records, psychological records, psychiatric records, problem lists, medication lists, lists of allergies, immunization records, history and physicals, discharge summaries, laboratory results, x-ray and imaging reports, medical images of any kind, video tapes, photographs, consultation reports, correspondence, itemized invoices and billing information, and information pertaining to Medicaid or Medicare eligibility and all payments made by those agencies, for the following dates:

Dates of Services - From:_____ To: _____

(Note: List the date range for which the medical providers and insurance companies above may have records relevant to the resolution of your PI Claim. If you are unsure of the exact dates, then leave this blank, and we will complete this section for you with the understanding that you authorize all relevant date ranges).

3. I understand that the information in my health records 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, as well as treatment for alcohol and drug abuse.

4. The health information may be disclosed to and used by the following individual and/or organization:
    a. Purdue Personal Injury Trust
    b. Edgar C. Gentle, III., of Gentle, Turner & Benson, LLC, as the Trustee and Claims Administrator of the Purdue Personal Injury Trust
    c. Med Lien Solutions

5. I understand I have the right to revoke this authorization at any time. I understand 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 10 years after the date that I sign it.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and forego a recovery under the Purdue Pharma L.P. PI Trust Distribution Procedures for Non-NAS or NAS PI Channeled Claims. I understand that no organization may condition treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1634.524. I understand 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 or HIPAA. If I have questions about disclosure of my health information, I can contact the parties listed above in section #4.

_____ _____

Patient or Legal Representative Date

_____

Relationship to Patient (If signed by Legal Representative)