For Official Use Only

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: (________)____

AZ

SECTION C: NAME OF PROVIDER(S) WHO ADMINISTERED ZOLADEX®

____

Please Print or Type Name of Provider(s)

SECTION D: PURCHASE INFORMATION

Medicare records indicate that you took Zoladex® on or about the dates shown in the chart below (Column A).

You must complete the rest of the chart by checking the appropriate box in Columns B or C, if they apply.

(1) If you paid **in full a percentage co-payment** for Zoladex®, place a check mark in Column B next to the date. Do not place a check mark for any dates for which your percentage co-payment was covered in full by insurance. (In other words, you are not entitled to receive a settlement payment if your percentage co-payment was paid in full by insurance or if you were entitled to have your co-payment paid in full by insurance but did not submit a claim to your insurance company.)

(2) If you had supplemental insurance that covered **part** of your percentage co-payment for Zoladex® at any time, but you **still** paid a percentage co-payment as well, place a check mark in Column C. Do not place a check mark next to any dates for which your insurance only required you to pay a flat co-payment.

A **Date of Zoladex® Administration**	B **I made a full percentage co-payment for this administration**	C **I made a partial percentage co-payment for this administration**

<u>SECTION D: PURCHASE INFORMATION</u> *(continued)*

A **Date of Zoladex® Administration**	**B** **I made a full percentage co-payment for this administration**	**C** **I made a partial percentage co-payment for this administration**

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.