Common Benefit Trust
Breast Implant Explant Financial Assistance Program

APPLICATION FOR EXPLANT ASSISTANCE

Use this form to apply for up to $5,000 in financial assistance for breast implant removal surgery. Covered expenses up to $5,000 are: surgery fees for explantation, capsulectomy and mastopexy (lift); anesthesiology, and operating room. Surgery fees for other reconstructive surgery or replacement breast implants are not included and are your financial responsibility.

INSTRUCTIONS FOR COMPLETING THIS FORM:

First, please complete the sections **NAME & CONTACT INFORMATION**, **PROOF OF IMPLANTATION** and **HEALTH INSURANCE COVERAGE** on pages 1-3. Your Application cannot be processed without this information. We also ask you to complete the section on **REASONS FOR NEEDING EXPLANT SURGERY** on page 4. This section is for our informational purposes only; and there are no reasons for needing explant surgery that would normally disqualify an Application for financial assistance.

Please circle either 'Yes' or 'No', or the other choices indicated, unless an explanation is requested.

If you are not sure about an answer or a response, please say so, and provide the answer or response to the best of your memory. We will ask you to explain any responses if clarification is needed.

When you complete the Form, sign and date it in the space provided on page 4, and follow the mailing instructions directly underneath.

NAME & CONTACT INFORMATION

Current Last Name:_____ Former Last Name(s):_____

First Name:_____ Middle Name:_____

Birthdate___/__/_____
(month/day/year)

Street/PO Box/Apt No:_____

City_____ State____ Zip Code_____

Phone Number(s)
Home: _____

Work: _____

Cell: _____

E-mail_____

How did you find out about the Explant Financial Assistance Program? (circle as many as apply)

NCHR Insurance Coverage Assistance explantassistance.com plastic surgeon

social media acquaintance

If you circled social media or plastic surgeon, please identify the group, or surgeon:

_____

PROOF OF IMPLANTATION

In this section, you will provide information and proof about the breast implants that you want surgically removed.

Date Implant(s) Received (month/day/year)_____

Place of Surgery and Physician's name_____

Circle which sides were implanted: Both Left Right

Type of Implant(s) (circle one) Gel-Filled Saline-Inflatable Double Lumen

Were the implants implanted after a mastectomy? Yes No

Have these implants been removed from your body? Yes No

If the answer is yes, provide the month/day/year and place each one was removed:

_____

As proof that I have these breast implants, I am including the following with this Application (check entry):

___ A copy of the plastic surgeon's report of the operation in which I received the above implants

___ I am not able to get a copy of the plastic surgeon's report of the operation. I am submitting a copy of other records from the plastic surgeon that implanted the above implants. (Examples are exam and appointment notes, breast implant labels/stickers, manufacturer brochures, etc.)

___ I am not able to get a copy of the plastic surgeon's report, nor do I have other documents from my operation. I am attaching a signed **IMPLANT PROOF WITNESS FORM** filled out and signed by a person who knew me *at the time I had breast implant surgery* who recalls the circumstances of my operation. (A copy of this form is available for download at http://www.explantassistance.com)

___ The implants I need to have surgically removed were implanted in me before June 1, 1993 and I participated in the MDL-926 Revised Settlement Program. By checking this entry I am authorizing the Program Administrator to access information about my claim as Proof of my implants.

A decision for financial assistance cannot be made without providing proof of your implants according to one of the above entries.

Provide the following answers only if you received the implants now in need of surgical removal before June 1, 1993.

Did you participate in either or both of the Breast Implant Settlement Programs? Yes No

If the answer is 'yes', circle the following settlement programs in which you participated:

MDL-926 Dow Corning

HEALTH INSURANCE COVERAGE

In this section, if you have health insurance through an insurance company, including an insurance company in connection with Medicare, you will provide information confirming that you have made a request to the company for coverage of your explant surgery that has been denied.

Do you now have health insurance? Yes No

If the answer is 'yes', circle the type(s) of insurance coverage that you now have:

Insurance Policy Medicare with Insurance Policy Medicare Only Medicaid

If your health insurance coverage is through an insurance policy, provide the name of the insurance company and the name of the policy:

_____

If your health insurance coverage is through an Insurance policy (including a policy with Medicare), when did you, or someone on your behalf (such as a plastic surgery practice) make a request for coverage of your explant surgery? (month/date/year)_____

What reason(s) were given by the insurance company for the denial of the request?

_____

If your breast implants have already been removed from your body, did an insurance company, Medicare, or Medicaid pay for at least part of the costs of the explant surgery?

Not Applicable (still have implants) No Yes

If you have not made a request for coverage to your <u>current</u> insurance company, you should not send in this Application i) until you have made a request ii) that has been denied.

If you have already had your breast implants removed and at least part of the explant surgery was paid for by an insurance company, Medicare, or Medicaid, you are not eligible for explant financial assistance.

If you are trying to find out whether your health insurance policy will cover the explant surgery or find it difficult to obtain information, you can contact the <u>Insurance Coverage Assistance Program</u>, operated by the National Center for Health Research, at 202-223-4000. This is a public advocacy group specializing in womens' health issues, including insurance coverage for breast implant removal.

REASONS FOR NEEDING EXPLANT SURGERY

Briefly explain why you now need to have your breast implants removed. If a physician has discussed the current condition of the implant(s) with you, and/or has told you the implant(s) need to be explanted, please summarize what the physician has told you:

_____

_____

_____

_____

Please Sign Here:

_____
Printed Name of Applicant

_____
Signature of Applicant

Date of Signature:____/___/_____
(month / day / year)

Send this Application with Proof of Implantation by U.S. mail to:

CBT Explant Assistance Program
P.O. Box 1028
Birmingham, AL 35201

WHAT HAPPENS AFTER I SEND IN THE APPLICATION?

If your Application is complete, it will be logged-in and reviewed.

You will be informed by mail if you are approved for Explant Financial Assistance.

If you are approved, you will receive further instructions with a **RELEASE AND MEDICAL PROVIDER DIRECT AUTHORIZATION FORM** and an IRS **Form W-9**, both for your completion and signature; with a **COST OF SURGERY CERTIFICATION FORM** for your plastic surgeon to complete and sign.

PLEASE NOTE THAT THIS PROGRAM HAS LIMITED AVAILABLE FUNDS AND MAY BE MODIFIED OR TERMINATED AT ANY TIME.