

**Common Benefit Trust**  
**Breast implant Explant Financial Assistance Program**

P.O. Box 1028  
Birmingham, AL 35201

Telephone: 205-252-6784  
<http://www.explantassistance.com>

The Common Benefit Trust has established a program to provide financial assistance to as many eligible women as funds permit in the form of a payment limited to no more than \$5,000 made directly to the plastic surgeon who performs the explantation surgery.

**YOU MAY BE ELIGIBLE FOR THE PROGRAM IF**

**EVERY ONE OF THE FOLLOWING STATEMENTS APPLIES TO YOU...**

- 1) You still have at least one silicone gel-filled or double-lumen type breast implant in your body that was implanted before December 31, 2006, and
- 2) You can document that this breast implant(s) is ruptured or that it is otherwise medically necessary that it be removed, and
- 3) If you are 65 or over, you are not, to the best of your knowledge and efforts, able to receive Medicare coverage for explantation surgery, and
- 4) You do not have private health insurance that will cover the explantation of this breast implant(s), or within the past two years a private insurance company has denied your request to pre-approve coverage for explantation of this breast implant(s), and
- 5) You do not have the ability to pay for the explant surgery, and
- 6) You did not receive any rupture or explantation benefit from the MDL 926 Revised Settlement Program ('RSP') or the Dow Corning Settlement Program, and
- 7) You did not enter into a private settlement agreement with the manufacturer of your breast implants, or obtain a judgment against it: **and**
- 8) You are willing to agree not to replace your breast implant(s) with a silicone gel or double lumen breast implant.

**IF YOU SATISFY ALL EIGHT OF THESE REQUIREMENTS, you may complete and submit the following Notice of Interest.**

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

**Common Benefit Trust  
Breast Implant Explant Financial Assistance Program**

**NOTICE OF INTEREST IN EXPLANT ASSISTANCE**

Use this form to express your interest in receiving up to \$5,000 in financial assistance for breast implant removal surgery.

**INSTRUCTIONS FOR COMPLETING THIS FORM:**

There are five sections to be completed: NAME & CONTACT INFORMATION, IMPLANT HISTORY, HOUSEHOLD INCOME, CLAIMS HISTORY, and MEDICAL INSURANCE COVERAGE. Please read through the entire form before filling it out. If you have documents concerning your breast implants, review them in order to refresh your memory and keep the records, as we may ask for them at a later time. Please complete all sections in order for your Notice of Interest to receive consideration.

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

Feel free to explain anything on a separate sheet of paper if the need arises.

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. If you have a question(s) about how to respond, the Program Administrator is available to answer your question(s) at the address and number provided at the top of page 1. If you are determined to be preliminarily eligible for assistance and are invited by us to submit an application for financial assistance as a result of these answers, you will be asked to certify them with your signature, so it is important to be as accurate as possible in completing this form.

Once you complete the Form, follow the submission instructions at the end of this form.

**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)

Social Media Group

Website

Plastic Surgeon/Medical Professional

Acquaintance/Friend

If you circled Social Media Group, Website, or Plastic Surgeon/Medical Professional, please identify the group, website, or medical professional:

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## **IMPLANT HISTORY**

Please provide information about all of the breast implants that you have received. If you have only one implantation surgery, skip the entry below for the Second Breast Implant(s). If you have had more than two implantation surgeries, attach a blank sheet of paper to describe the third and any further surgeries in which implants were received.

### **First Breast Implant(s)**

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:

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### **Second Breast Implant(s)**

Date Implant(s) Received (month/date/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:

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### Reasons for Needing Explantation

Briefly explain why you now need to have your breast implants which were implanted before December 31, 2006 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 identify the physician and summarize what he/she has told you:

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If applicable, provide the name and address of any plastic surgeon who has told you that he/she would be willing to do your explantation surgery:

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## HOUSEHOLD INCOME

How many other people lived with you full-time in your household in 2016 (not counting yourself)? \_\_\_\_

What is the total monthly gross income for your household? Total monthly gross income means all money received by you and everyone else in your household, from all sources. (If the total income varies from month-to-month, add up your income for the year 2016 and divide by 12 to provide an average total monthly income.)\$ \_\_\_\_

Do you have the ability to pay for breast implant explantation surgery (NOTE: inability to pay for explantation surgery may include special or extenuating circumstances in your life that would prevent you from using income that would normally be available to you to pay for the surgery)?

Yes    No

If you answered 'no' to the preceding question, please briefly explain why you do not have the ability to pay for explantation surgery,

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## **CLAIMS HISTORY**

Have you ever sued a company that manufactured breast implants?      Yes      No

*If you circled 'No', skip the next question.*

If you sued a company that manufactured breast implants, did you ever enter into any private settlement with the breast implant manufacturer or obtain a court judgment against one? (Do not include any settlement from the two breast implant settlement programs referred to below)

Yes      No

Did you participate in either of the breast implant settlement programs?      Yes      No

*If the answer is 'no', go to the **MEDICAL INSURANCE COVERAGE** Section.*

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

MDL-926      Dow Corning

If you circled 'MDL-926', did you receive the \$3,000 explantation benefit?      Yes      No

If you circled 'MDL-926', did you receive a rupture enhancement payment?      Yes      No

If you circled 'Dow Corning', did you receive the \$5,000 explantation benefit?      Yes      No

If you circled 'Dow Corning', did you receive the rupture benefit?      Yes      No

If you circled 'MDL-926', please put your initials on the line next to the statement below:

\_\_\_\_ I hereby do authorize the Program Administrator to access information about my claim in the MDL-926 Registration database.

## **MEDICAL INSURANCE COVERAGE**

Do you now have medical insurance coverage?      Yes      No

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

Medicare                      Medicaid                      Private Insurance Policy

If your medical insurance coverage is through a private insurance policy, provide the name of the insurance company and the name of the policy:

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If your medical insurance coverage is through a private insurance policy, state the month/day/year that coverage started)? \_\_\_\_/\_\_\_\_/\_\_\_\_

Has a private insurance company denied a request made by you or on your behalf (such as by a physician's office) within the past two years for coverage for surgery to remove your breast implant(s)?

Yes No

If the answer to the preceding question is 'Yes', identify the insurance company and describe the circumstances of the request: the date the request for coverage was made, whether the request was made directly by you or by someone on your behalf, and the reasons for the denial of the request:

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#### **SUBMISSION INSTRUCTIONS**

**DEADLINE FOR SUBMISSION: December 31, 2017**

Submissions must be made by U.S. mail to:

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

When mailing this form, we recommend that you include USPS Tracking™ in your postage costs so that you can verify that we have received your Notice of Interest. After your Notice of Interest is reviewed, you will be informed of our determination in writing; as to whether you are eligible or ineligible at this time to apply for Explant Financial Assistance. If you are eligible, you will receive an Application Package including a request for supporting documentation of some of the information provided in this form, along with further instructions.

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