Dental Crown Settlement

***Bhatia v. 3M Co.*, No. 0:16-cv-01304**
U.S. District Court for the District of Minnesota

SUPPLEMENTAL CLAIM FORM
For Full or Partial Debonds Repaired at Any Time from May 10, 2019 through September 7, 2020

Complete this Supplemental Claim Form if you are a dentist or dental practice in the United States, Commonwealth of Puerto Rico, U.S. Virgin Islands, or Guam who purchased 3M ESPE Lava Ultimate CAD/CAM Restorative ("Lava Ultimate"), applied the product as a dental crown before June 15, 2015, and had patients who experienced one or more full or partial debonds that you repaired or paid to have repaired at any time from May 10, 2019 through September 7, 2020.

You can submit an electronic Supplemental Claim Form in just a few quick and easy steps on the settlement website at www.DentalCrownSettlement.com. The online filing system is quicker, more efficient, and will ask you only those questions required for your claim.

If you cannot submit your claim online, complete, sign, and return this Supplemental Claim Form to: Dental Crown Settlement Claims Administrator, P.O. Box 26207, Richmond, VA 23260.

You must submit your Supplemental Claim Form online at www.DentalCrownSettlement.com or mail it postmarked on or before December 15, 2020.

I. CLAIMANT INFORMATION

The Claims Administrator will use this information for all communications relevant to this claim. If your contact information changes, you must notify the Claims Administrator in writing at the mailing or email address above. **While both dentists and dental practices are eligible to participate in the Settlement, the person or entity that made the purchase of Lava Ultimate should file the claim. In other words, if the practice made the purchase, the practice is the correct Claimant Name to enter below. Duplicate claims will not be allowed.**

Notice ID (Your unique Notice ID appears on the envelope that enclosed your Supplemental Class Notice.)				
Claimant Name (The Claimant is the entity or person who purchased Lava Ultimate.)	Last Name/Business Name	First Name	Middle Name	
Name and Title of Person Filling Out this Form	Last Name	First Name	Middle Name	Title
Taxpayer Identification Number	__ __ __ __ __ __ __ __ __	**Telephone Number**	(_____) _____-_____	
Mailing Address	Street/P.O. Box			
	City	State	Zip	
Contact Email (By providing an email address, you are authorizing the Claims Administrator to provide you with information relevant to your claim by email.)				

II. BASIC CLAIM INFORMATION

Tell us about the 3M ESPE Lava Ultimate CAD/CAM Restorative blocks you purchased, returned, and seated as crowns.

QUESTION 1: BLOCKS PURCHASED	
How many 3M ESPE Lava Ultimate CAD/CAM Restorative blocks did you purchase from 3M or a third-party dental supply company prior to June 15, 2015?	
QUESTION 2: 3M BUYBACK PROGRAM (BLOCKS RETURNED)	
Of the number of 3M ESPE Lava Ultimate CAD/CAM Restorative blocks stated in response to Question No. 1, how many did you return to 3M or a third-party dental supply company?	
QUESTION 3: BLOCKS SEATED AS CROWNS	
How many 3M ESPE Lava Ultimate CAD/CAM Restorative blocks did you seat as crowns prior to June 15, 2015?	
QUESTION 4: TOTAL DEBONDS REPAIRED	
How many of the crowns stated in response to Question No. 3 debonded and were repaired at any time from May 10, 2019 through September 7, 2020?	

III. CLAIM TYPE ELECTIONS

For each repaired debond listed in response to Question No. 4, you may request (1) a Fixed Amount of $250, which requires no supporting documentation, or (2) the Documented Amount of your actual out-of-pocket losses that you incurred as a result of the debond, which does require supporting documentation for each affected tooth.

You may NOT make a claim for both a Fixed Amount and a Documented Amount for the same debond.

A. FIXED AMOUNT CLAIM INFORMATION

This section relates to the repaired debonds for which you are making a claim for a Fixed Amount. You do not need to provide any supporting documentation for these debonds.

QUESTION 5: FIXED AMOUNT DEBONDS	
Of the total number of repaired debonds stated in response to Question No. 4, for how many are you requesting the Fixed Amount of $250 per debond? If you are claiming a Fixed Amount for all your debonds, you may skip Section IV.B.	

B. DOCUMENTED AMOUNT CLAIM INFORMATION

This section relates to the repaired debonds for which you are making a claim for a Documented Amount. You must provide supplemental information and supporting documentation for each of these debonds. Answer Question Nos. 6 and 7, complete the Documented Amount Claim Table on page 5, and confirm that you have included all required documentation listed in the "Required Proof for Documented Amount Claims" section of this Supplemental Claim Form.

QUESTION 6: DOCUMENTED AMOUNT DEBONDS	
Of the total number of debonds stated in response to Question No. 4, for how many are you requesting the Documented Amount? [Note: The sum of the numbers provided in response to Question Nos. 5 and 6 must not exceed the number stated in response to Question No. 4.]	

QUESTION 7: TOTAL DOCUMENTED AMOUNT CLAIM	
What is the total out-of-pocket loss you are claiming as a result of the repaired debonds identified in your response to Question No. 6?	

REQUIRED PROOF FOR DOCUMENTED AMOUNT CLAIMS

You must submit a Documented Amount Claim Form Support Package that includes all required documents **for every repaired debond for which you are requesting a Documented Amount.** Check the boxes below to confirm that your proof shows the following for each affected tooth:

- ☐ Placement of a Lava Ultimate crown prior to June 15, 2015;
- ☐ Patient billing records relating to each such placement, and relating to all subsequent procedures for the tooth, including any records of payments received from the patient, an insurance provider, or other, if applicable;
- ☐ A debond, including contemporaneous notes or records that show the debond or indications that repairs, reseating, replacement, or other patient treatment was necessary;
- ☐ Unreimbursed costs spent repairing the debond or otherwise treating the patient as a result of the debond, including material costs and costs to the Authorized Claimant for dental work performed by a specialist (e.g., root canals, gingivectomy procedures, extractions, or implants); and
- ☐ Any additional unreimbursed out-of-pocket costs attributed to the debond that can properly be documented.

Such documents include patient treatment notes and records, digital images, patient billing and payment records, any applicable insurance records, and records of any costs you incurred and paid in repairing the debond, treating the patient, or having the patient treated by another dentist or specialist.

You must number every page of your Documented Amount Claim Form Support Package and reference those page numbers in Column H of the Documented Amount Claim Table on page 5 of this Supplemental Claim Form.

DOCUMENTED AMOUNT CLAIM TABLE

Complete the Documented Amount Claim Table on page 5. You must complete one row per debond for which you are requesting a Documented Amount. If you need more space, copy the Document Amount Claim Table, fill it out, and attach it to this Supplemental Claim Form.

IV. CONFIDENTIALITY

All information you submit will be kept confidential by the Claims Administrator and counsel for the Parties. It will not be used for any purpose other than administering your claim and determining the amount, if any, of your payment. It will not be disclosed to anyone except the Claims Administrator, counsel for the Parties, and potentially a retired United States Magistrate Judge, whom the Stipulation of Settlement appoints to be the final decision-maker on any disputes concerning your claim.

V. AGREEMENTS AND RELEASE OF CLAIMS

By submitting this Supplemental Claim Form, I (we) agree to the following under penalty of perjury:

1. The information in this Supplemental Claim Form is true and accurate to the best of my (our) knowledge, information, and belief.
2. I (we) am a Class Member in the above-identified action and did not request to be excluded from the Class or the Settlement.
3. I (we) am bound by the terms of the Stipulation of Settlement dated March 25, 2019 ("Stipulation"), on file with the Court in the above-identified action.
4. I (we) submit to the jurisdiction of the United States District Court for the District of Minnesota with respect to my (our) claim as a Class Member.
5. I (we) have read and agree to the release described in paragraph IV(B)(13) of the Stipulation of Settlement, and understand and agree that upon the Effective Date of the Settlement (as defined in paragraph IV(A)(17) of the Stipulation), I (we) will be deemed to have released any and all Released Plaintiffs' Claims (as defined in paragraph IV(A)(25) of the Stipulation) against Defendant 3M Company and Defendant's Releasees (as defined in paragraph IV(A)(16) of the Stipulation) and will permanently barred and enjoined from asserting those claims.
6. I (we) understand that this claim will be subject to review, audit, and verification. If further information or documents are required in order to review, audit, and/or verify my (our) claim, I (we) will provide them.
7. I (we) have not submitted any other claim in the above-identified action covering the Debonds, and know of no other person or entity having done so on my (our) behalf.
8. I have not assigned or transferred (or purported to assign or transfer), voluntarily or involuntarily, any matter released by the Settlement.

Signature			**Date**	_____/_____/_____ (Month/Day/Year)
Printed Name	First	Middle	Last	

ACCURATE PROCESSING OF CLAIMS MAY TAKE SIGNIFICANT TIME.
THANK YOU IN ADVANCE FOR YOUR PATIENCE.

THIS SUPPLEMENTAL CLAIM FORM MUST BE POSTMARKED BY NO LATER THAN DECEMBER 15, 2020.

DOCUMENTED AMOUNT CLAIM TABLE

You must complete one row per debond for which you are requesting a Documented Amount. If you need more space, copy the Document Amount Claim Table, fill it out, and attach it to this Supplemental Claim Form.

A	B	C	D	E	F	G	H
Debond Incident Number	**Patient Identifier (name or number)**	**Tooth Number**	**Date of Debond Repair**	**Total Monetary Loss for Debond**	**Description of Unreimbursed Out-of-Pocket Costs**	**Total Amount of Unreimbursed Out-of-Pocket Loss for Debond**	**Page # of Documented Amount Claim Form Support Package**
1.							
2.							
3.							
4.							
5.							