INAMED CLAIM FORM

CLAIMANT'S NAME (first name, middle initial, last name)	Social Security or MDL Reg. No.
CLAIMANT'S MAILING ADDRESS (include city, state, country, zip)	Date of Birth (mo/dy/yr)

ATTORNEY'S NAME and MAILING ADDRESS (Leave blank if unrepresented.)

Complete if, but only if, you know that you were implanted before June 1, 1993, with one or more breast implants (or tissue expanders) named on the back of this form. All information must be printed legibly and in English. You must attach confirmation of the brand you received. See instructions about required confirmation on the reverse side.

If you are a citizen of the United States you must provide your Social Security number. If you are a citizen of another country, provide the registration number previously provided by the Claims Office; if no registration number has been provided, leave blank.

Before June 1, 1993, I was implanted with at least one implant named on the back of this form. Attached is the required confirmation of the brand I received.

____________________________ ____________________________

Date of Implantation (Month/Day/Year) Brand of Implant

Under penalties of perjury, I affirm that -- to the best of my knowledge, information, and belief, formed after a reasonable inquiry -- the above statements are true, correct, and complete and are made to claim benefits from the Inamed settlement fund.

____________________ ______________________________________

Date Signed Signature of implant recipient, the executor or administrator of her estate, or her legal guardian

If eligible, complete and sign form. Attach required confirmation. Mail to:

MDL-926 Claims Office
PO Box 56666
Houston, TX 77256 USA

Completed and signed claim forms, with required confirmation attached, must be received by the Claims Office by October 1, 1999.

Late or incomplete claims will not be paid.