TRUST CLAIM FORM

This claim form sets forth your claim for recovery under the Tronox Incorporated Tort Claims Trust Distribution Procedures ("**TDPs**"). Capitalized terms not defined in this claim form are defined in the TDPs and the Instruction Letter. Please review the documents and claims materials carefully. ***Nothing in this Trust Claim Form, the Cover Letter, or the Instruction Letter is intended to replace or modify the requirements of the Plan, the TDPs, or the ADR Procedures. All Claimants are encouraged to read thoroughly and understand the TDPs and the ADR Procedures before filing a Tort Claim.***

Please carefully follow all of the instructions in this claim form and complete it as thoroughly and accurately as possible. Should there be insufficient space to list all of the relevant information, please attach additional sheets.

In addition to filing this claim form, you may need to provide certain documents to support your Claim. Please review the instructions in this form carefully and enclose any required documentation.

You must submit all of the information you want the Trust to consider at this time. The only information the Trust will consider is the information it has at the time it reviews your claim.

Once this claim form is completed, it must signed by the Claimant or the Claimant's attorney. If you are represented by an attorney, it is important to ask him or her any questions you have about this claim form before you sign it. If someone else prepared this claim form for you, review its contents carefully. You are responsible for the accuracy of all information provided to the Tort Claims Trust in this claim form.

PART 1: LEGAL REPRESENTATION			
A. Attorney Name:	Last Name (*and suffix, if applicable*)	Given Name (First)	M.I.
B. Law Firm Name: _____			
C. Law Firm Address:	Street Number and Street Name		Suite or Floor
	City	State	Zip Code
D. Attorney Contact Information:	**Phone** _____ **E-mail** _____		
E. Paralegal or Contact Name:	Last Name (*and suffix, if applicable*)	Given Name (First)	M.I.
F. Contact Information for Paralegal or Contact Person:	**Phone** _____ **E-mail** _____		

PART 2: INJURED PARTY INFORMATION

A. Current Legal Name:

Family Name (Last), *and suffix if applicable* | Given Name (First) | M.I.

B. Identification Number: U.S. Social Security Number: __ __ __ - __ __ - __ __ __ __

Or Alternate Identification Type: No.:

C. Date of Birth: __ __ / __ __ / __ __ __ __
Month **Day** **Year**

D. Address:

If the Injured Part is deceased, please use the Injured Party's address at the time of his or her death.

Street Address | Apt. No.

City | State | Zip Code

E. Contact Info.: **Phone** _____ **E-mail** _____

F. Is the Injured Party deceased? ☐ **Yes** ☐ **No**

If *Yes*, please provide the date of death: __ __ / __ __ / __ __ __ __
Month **Day** **Year**

G. Death Certificate: If the Injured Party is deceased and you are filing a Claim on his or her behalf, you must attach a copy of the Injured Party's death certificate to this claim form. If the Injured Party is deceased, but you are not able to provide a copy of his or her death certificate, please explain why in the space below.

Check One of the Following:

☐ A copy of the Injured Party's Death Certificate is attached.

☐ A copy of the Injured Party's Death Certificate is ***NOT*** attached, for the following reason:

_____

_____

_____

*

PART 3: OFFICIAL REPRESENTATIVE OF DECEASED, INCOMPETENT, OR MINOR INJURED PARTY

A. Current Legal Name:

Last Name (*and suffix, if applicable*) | Given Name (First) | M.I.

B. Address:

Street Number and Street Name | Apt. No.

City | State | Zip Code

C. Contact Info.: **Phone** _____ **E-mail** _____

D. Certificate of Official Capacity or Other Estate Documentation: If you are the Injured Party's personal representative and the applicable state's law requires you to obtain a certificate of official capacity or other documentation to show that you are authorized to act on the Injured Party's behalf, you must attach a copy of the certificate or other documentation to this claim form. If you are acting on behalf of the Injured Party but are unable to attach a copy of the certificate of official capacity or other documentation, please explain why in the space below.

Check One of the Following:

☐ A copy of the certificate of official capacity or other estate documentation required by applicable state law is attached.

☐ Applicable state law does not require a certificate of official capacity or other estate document, and therefore no certificate is attached.

☐ A copy of the certificate of official capacity, although required by state law, is ***NOT*** attached, for the following reason:

_____

_____

_____

PART 4: CATEGORY A FUTURE TORT CLAIMS

A. Your Illness, Injury, or Physical Condition

Please identify the illness, injury, or physical condition that you claim was caused by your exposure to a product or toxin manufactured, stored, or disposed of, or other property owned, operated or used for storage or disposal by, Tronox or any Entity for whose products or operations Tronox allegedly has liability. ***If you are claiming more than one illness, injury, or physical condition, please complete a copy of this page for each such illness, injury, or physical condition.***

_____

B. Date of First Diagnosis

Please identify the date or approximate date on which you were first diagnosed with this illness, injury, or physical condition.

Date of First Diagnosis: __ __ / __ __ / __ __ __ __
Month **Day** **Year**

C. Product or Toxin to Which You Were Exposed

Please identify the product or toxin to which you were exposed that you claim caused this condition (e.g., asbestos, benzene, creosote, silica).

_____

D. Date of First Alleged Exposure

Please identify the date or approximate date on which you believe you were first exposed to this product or toxin.

Date of First Alleged Exposure: __ __ / __ __ / __ __ __ __
Month **Day** **Year**

PART 5: PROOF OF REPRESENTATION

Before the Trust can pay any award to which you may be entitled, it must verify whether you are required to use any of the award money to reimburse the federal government or the Medicaid agency in your state of residence for any Medicare Part A and B or Medicaid payments they respectively made on behalf of the Injured Party for medical items or services related to the disease or injury that you are claiming against the Trust. To perform this task, the Trust needs you to complete one of the two Proof of Representation forms included with the claims packet. ***If you do not complete the correct Proof of Representation form, the Trust will not be able to pay you any money.***

If you are represented by an attorney, please complete the Proof of Representation Form that has an "X" in the space labeled "Attorney" under the "Type of Representative" heading. If you are not represented by an attorney, please complete the Proof of Representation Form that has an "X" in the space labeled "Person/Organization other than an Attorney" under the "Type of Representative" heading. In addition, please check the box below to indicate which form you completed:

☐ (1) I have completed the Proof of Representation for claimants represented by an attorney and am attaching it to this Trust Claim Form;

OR

☐ (2) I have completed the Proof of Representation for claimants ***not*** represented by an attorney and am attaching it to this Trust Claim Form.

PART 6: RECOVERY FROM OTHER DEFENDANTS

All Claimants must provide information concerning any recoveries the Injured Party (or the Injured Party's Official Representative) received from other defendants and claims-resolution organizations related to the Injured Party's Claim. Check the boxes below that best identify the status of any recoveries from other defendants:

☐ (1) The Injured Party (or the Injured Party's Official Representative) has ***not*** asserted a claim related to the one asserted above against another defendant or claims-resolution organization.

☐ (2) The Injured Party (or the Injured Party's Official Representative) has received payment (or has a right to receive payment) from another defendant or claims-resolution organization on a claim related to the one asserted above.

If you checked box 2, please provide the following information:

A. Payer's Name: _____

B. Payer's Address: _____
Street Number and Street Name Suite or Floor

_____
City State Zip Code

C. Payer's Contact Information: **Phone** _____ **E-mail** _____

D. Amount of Payment: _____

E. Source of Payment: _____

F. For Payments from Court Awards and Settlements:

(Please attach (1) a copy of the most recent complaint and (2) the verdict, order, or settlement agreement setting forth the amount of the award)

_____
Name of Case

_____ _____
Case Number Jurisdiction Where Case Was Pending

_____
Description of Claim

G. For Payments from Insurance: _____
Type of Policy Under which Payment Was Made (i.e., Liability, No-Fault, Workers' Compensation)

_____ _____
Policy Number State in which Policy Was Issued

☐ (3) The Injured Party (or the Injured Party's Official Representative) has asserted a claim against another defendant or claims-resolution organization that is related to the Claim asserted above, and the claim has not yet been resolved (whether by verdict, judgment, settlement, or otherwise).

If you checked box 3, please provide the following information:

A. Defendant's/ Organization's Name:

B. Defendant's/ Organization's Address:

Street Number and Street Name — Suite or Floor

City — State — Zip Code

C. Defendant's/ Organization's Contact Information:

Phone _____ **E-mail** _____

D. Case/Claim Information:

(Please attach a copy of the most recent complaint or clam form)

Name of Case/Claim

Case/Claim Number — Jurisdiction Where Case /Claim Is Pending

Description of Case/Claim

☐ (4) The Injured Party (or the Injured Party's Official Representative) had asserted a claim against another defendant or claims-resolution organization that was related to the Claim asserted above, and the claim was dismissed with prejudice or was denied.

If you checked box 4, please provide the following information:

A. Defendant's/ Organization's Name:

B. Defendant's/ Organization's Address:

Street Number and Street Name — Suite or Floor

City — State — Zip Code

C. Defendant's/ Organization's Contact Information:

Phone _____ **E-mail** _____

D. Case/Claim Information:

(Please attach a copy of the order or notice dismissing or denying the case or claim)

Name of Case/Claim

Case/Claim Number

Jurisdiction Where Case /Claim Was Pending

Description of Case/Claim

*

PART 7: SIGNATURE PAGE

All Claims must be signed by the Claimant or the Claimant's attorney.

If signed by the Claimant: I (the Injured Party or the Injured Party's Official Representative) have reviewed the information submitted on this claim form and all documents submitted in support of this claim. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury under the laws of the United States of America that the information submitted is true and correct.

If signed by the Claimant's attorney: I (counsel to the Injured Party or the Injured Party's Official Representative) certify that the information and materials with respect to this claim are being submitted pursuant to and subject to the provisions of Rule 11 of the Federal Rules of Civil Procedure.

_____
Signature of Claimant or Claimant's Attorney

_____
Please print the name and relationship to the Injured Party of the signatory above

Date: _____/ _____/ _____
(month) (day) (year)