PAXIL® PEDIATRIC CLAIM FORM
I'D LIKE A PAYMENT FROM THE PAXIL® PEDIATRIC SETTLEMENT.

Complete and mail to the address below; it must be received by **August 31, 2007**.

Your Name

Years in Which Paxil® was Prescribed and Purchased for Patient

Your Address

Patient's Date of Birth

Your City, State, Zip

Name of Doctor who Prescribed Paxil® for Patient

Insurance Company at time of Paxil® Pediatric Purchase

Address of Doctor who Prescribed Paxil® for Patient

Your Relationship to Patient

Doctor's City, State, Zip

How much money did you pay, out of pocket, for Paxil® or Paxil CR® for which you have not been reimbursed from any source? Attach pharmacy receipts or other medical records showing the amount you paid. Documentation is required with this Claim Form but do not attach originals.*	$_____

I certify under penalty of perjury that the information above is true and correct and that the submission of false information may subject me to sanctions.

Signature

Date

Mail this form so that it is received by **August 31, 2007** to:

Paxil Pediatric Settlement Administrator
c/o Rust Consulting, Inc.
PO Box 555
Minneapolis, MN 55440-0555

* If you no longer have the receipt you may be able to get a copy from your pharmacy. If you still cannot obtain a receipt you can fill out the Claim Form stating you did purchase Paxil® or Paxil CR™ for a minor and obtain up to a $100 reimbursement. Please specify your exact out-of-pocket cost for Paxil® or Paxil CR™ which has not been unreimbursed. Please consult your doctor, pharmacy or income tax records for documentation of your purchase.

Questions? Call 1-877-347-6448 toll free