For Official Use Only

***Must Be Postmarked No Later Than* June 13, 2005**

Remeron® Consumer Claim Form

You may be eligible for a payment from the Remeron® Settlement if you choose to remain in the Settlement Class, and if you purchased Remeron® or generic mirtazapine (not SolTab®) at any time between June 15, 2001 and January 25, 2005.

If you wish to make a claim, you must complete this Claim Form and mail it to the address below, postmarked no later than **June 13, 2005**.

OR

You can file a claim on-line at: www.RemeronSettlement.com no later than **June 13, 2005**.

CLAIMANT INFORMATION

(Please Print or Type)

NOTE: *If you are a representative (such as a spouse, guardian, executor or personal representative) filing this claim on behalf of the patient, please provide YOUR name and address.*

Your Name: ____

Address: ____

______________________ ______________________ __________
City State Zip

Daytime Telephone Number: (__________)______________________

Patient's Name: *(if different from above)* ______________________

Last 4 Digits of Patient's Social Security Number: ______________________

Name of Doctor who prescribed Remeron® or generic mirtazapine: ______________________
(If more than one Doctor prescribed Remeron® or generic mirtazapine, please list most recent.)

Address of Prescribing Doctor: ______________________________________

______________________ ______________________ __________
City State Zip

CLAIMANT INFORMATION (continued)

When, between June 15, 2001 and January 25, 2005, did you purchase Remeron® or generic mirtazapine (not SolTab®)?

From: ______/_____/_____ To: ________/_____/_____

At any time between June 15, 2001 through January 25, 2005, did you have insurance for prescription drug coverage?

______Yes ______No

What is the total amount you paid for Remeron® or generic mirtazapine (not SolTab®) from June 15, 2001 through January 25, 2005? $ _____________

NOTE: *DON'T* include any amount you were reimbursed by insurance. *DON'T* include any purchases made when your insurance co-pay for generic drugs was the same as your co-pay for brand name drugs.

No documentation is required with this Claim Form, but you may be asked to provide some at a later time. Keep copies of your receipts. This claim may be rejected if you fail to respond to any request for documentation.

DECLARATION

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

______________________	______________	______________________
Signature	Date	Representative Capacity (if applicable)

FILING DEADLINES AND ADDRESSES

MAIL NO LATER THAN JUNE 13, 2005 TO:

Remeron® Settlement Administrator
c/o Complete Claim Solutions, Inc.
P.O. Box 24769
West Palm Beach, FL 33416

OR

FILE ON-LINE NO LATER THAN JUNE 13, 2005 AT:

www.RemeronSettlement.com

OTHER INFORMATION

I heard about the Remeron® Settlement:

- ☐ newspaper
- ☐ Reader's Digest
- ☐ Letter from my pharmacist
- ☐ Letter from my doctor
- ☐ Other: ____

If you have any questions about how to fill out any of the blanks on this form, please call the Settlement Administrator, toll-free, at 1-866-401-6807.