

**ENROLLMENT FORM: UNREPRESENTED CLAIMANTS**

This Enrollment Form pertains to the Settlement Agreement dated November 9, 2007, as amended at time since such date (“the Agreement”), incorporated herein by reference, including but not limited to the program for resolution of claims relating to the use of Vioxx described therein (generally and collectively referred to herein as the “Resolution Program” or “the Program”).

1. I hereby represent and certify that I have read the contents of the Settlement Agreement, as amended, and I understand, if my Enrollment Form is accepted under the terms of the Agreement: (1) participation in the Resolution Program subjects me to the authority of those persons specified in the Agreement, including, but not limited to, the Honorable Eldon E. Fallon, the Special Master, and any Deputy Special Masters; (2) in connection with entry into the Program I am releasing my claims against the entities and individuals identified in the Release of All Claims (“Release”) and that my Release may not be returned other than under the limited circumstances provided in Section 2.7 of the Agreement; (3) enrollment terminates any lawsuits which I have brought or could have been brought, other than as provided by Section 2.7, and no claim may be advanced other than as permitted under the Agreement; (4) the Resolution Program provides my sole and exclusive remedy for my claims, and that I will be bound by its results whatever they may be, other than as may be provided for under Section 2.7 of the Agreement; and (5) the potential benefits and risks to me if I enter the Resolution Program.
  
2. By submitting this Enrollment Form, I consent and agree to the terms of the Agreement. As required by the Agreement, if I have not done so already, I will execute and send to the Claims Administrator (a) an individual Stipulation of Dismissal with Prejudice (if I have a lawsuit pending); (b) a Release; (c) a Medical Records Authorization Form; and (d) if I am claiming past lost wages pursuant to section 4.2 of the Agreement, an Employment Authorization Form. With respect to the Medical Records Authorization and the Employment Records Authorization Form, I understand that I may be asked to sign additional copies of these Authorizations or other authorizations that may be required by the Claims Administrator, Merck & Co., Inc., or providers of the records. I agree to cooperate fully in promptly providing any additional authorizations upon request and to cooperate fully and promptly in providing any such other form of Stipulation of Dismissal with Prejudice, if requested.
  
3. I further acknowledge that under the terms of the Agreement, I will not be deemed to have been Enrolled until the Claims Administrator or Merck determines that the requirements of Section 1.2 of the Agreement have been met with respect to my claim.

**ACCEPTED AND AGREED:**

|   |                      |  |                               |              |  |
|---|----------------------|--|-------------------------------|--------------|--|
| <b>Date:</b> ___/___/___<br><small>(Month/Day/Year)</small> | _____                |  |                               |              |  |
|   | (Signature)          |  |                               |              |  |
| <b>Claimant's Name</b>                                      | Last                 | First                                  | Middle                        |              |  |
| <b>VCN</b>  | <b>Date of Birth</b> | / /<br><small>(Month/Day/Year)</small> | <b>Social Security Number</b> | - -          |  |
| <b>Address</b>  | Street               |  |                               |              |  |
|   | City                 |  | State                         | Zip          |  |
| <b>Telephone</b>  | ( ) ___-___          | <b>Facsimile</b>                       | ( ) ___-___                   | <b>Email</b> |  |