AFFIDAVIT OF MEDICARE BENEFICIARY STATUS

In connection with 42 U.S.C. 1395y(b)

STATE OF ___________ )
COUNTY OF ________ )

I, _________________________, being duly sworn, depose and affirm:

1. I am a party to a claim against Zimmer Biomet, Inc. and am executing this Affidavit in connection with that certain Final Settlement and Release Agreement dated ___________ ____, 20____.

2. I am / am not (circle applicable language) presently enrolled in Medicare.

3. I have / have never (circle applicable language) been enrolled in the past in Medicare.

4. I have completed, signed and returned to Zimmer Biomet, Inc., or its counsel, the Centers for Medicare & Medicaid Services Medicare Beneficiary Status Form attached hereto.

5. All information provided by me on each applicable form attached hereto is true and correct as of the date hereof.

I affirm, under penalties for perjury, that the foregoing representations are true.

____________________________________
Name of Claimant
*** Important. Please read carefully. ***

Pursuant to Section 111 of the Medicare, Medicaid & SCHIP Extension Act of 2007 ("MMSEA") (42 U.S.C. 1395y(b)(7) and (8)), Zimmer Biomet, Inc., is subject to certain data reporting requirements that arise if and when Zimmer Biomet, Inc., resolves a claim with a Medicare beneficiary in the form of a settlement, judgment, award or other payment. As a reporting entity under MMSEA, Zimmer Biomet, Inc., has access to a query function with the Centers for Medicare & Medicaid Services ("CMS") whereby it can verify a Medicare Health Insurance Claim Number ("HICN") for a given Medicare beneficiary, or it can determine whether or not an individual is a Medicare beneficiary from a person's Social Security Number ("SSN").

In connection with the claim you have asserted against Zimmer Biomet, Inc., please complete, sign and return the attached CMS Medicare Beneficiary Status Form (the "Form") to Faegre Baker Daniels, LLP. CMS has advised that all claimants cooperate in furnishing their HICN and/or SSN by completing and returning the Form as requested. Failure to cooperate may be a violation of your obligations under the Medicare Secondary Payer Statute and related regulations. (42 U.S.C. 1395y(b); 42 C.F.R. Part 411) For more information relating to the appropriateness of your cooperation in furnishing your HICN and/or SSN, please see the attached CMS Alert dated April 6, 2010.
Collection of Medicare Health Insurance Claim Numbers (HICNs), Social Security Numbers (SSNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers) – ALERT


(See 42 U.S.C. 1395y(b)(7)&(b)(8))

This ALERT is to advise that collection of HICNs, SSNs, or EINs for purposes of compliance with the reporting requirements under Section 111 of Public Law 100-173 is appropriate.

HICNs, SSNs and EINs:

• The Medicare program uses the HICN to identify Medicare beneficiaries receiving health care services, and to otherwise meet its administrative responsibilities to pay for health care and operate the Medicare program. In performance of these duties, Medicare is required to protect individual privacy and confidentiality in accordance with applicable laws, including the Privacy Act of 1974 and the Health Insurance Portability and Accountability Act Privacy Rule. The SSN is used as the basis for the Medicare HICN. While the HICN is required to identify a Medicare beneficiary, if the HICN is not available some beneficiaries may also be identified by the SSN. Please note that The Centers for Medicare & Medicaid Services (CMS) has a longstanding practice of requesting HICNs or SSNs for coordination of benefit purposes.

• The EIN is the standard unique employer identifier. It appears on the employee's federal Internal Revenue Service Form W-2, Wage and Tax Statement received from their employer. The Medicare program uses the EIN to identify businesses. The establishment of a standard for a unique employer identifier was published in the May 31, 2002 Federal register, with a compliance date of July 30, 2004.

A new Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers, third party administrators, and plan
administrators or fiduciaries of self-insured/self-administered group health plans to report, as directed by the Secretary of the Department of Health and Human Services, information that the Secretary requires for purposes of coordination of benefits. The law also imposes this same requirement on liability insurers (including self-insurers), no-fault insurers and workers' compensation laws or plans. Two key elements that are required to be reported are HICNs (or SSNs) and EINs. In order for Medicare to properly coordinate Medicare payments with other insurance and/or workers' compensation benefits, Medicare relies on the collection of both the HICN (or SSN) and the EIN, as applicable.

As a subscriber (or spouse or family member of a subscriber) to a group health plan arrangement, it is likely that your employer or insurer will ask for proof of your Medicare program coverage, by asking for your Medicare HICN (or your SSN) in order to meet the requirements of P.L. 110-173, if this information is not already on file with your insurer. Similarly, individuals who receive ongoing reimbursement for medical care through no-fault insurance or workers' compensation or who receive a settlement, judgment or award from liability insurance (including self-insurance), no-fault insurance, or workers' compensation will be asked to furnish information concerning whether or not they (or the injured party, if the settlement, judgment or award is based upon an injury to someone else) are Medicare beneficiaries, and if so, to provide their HICNs or SSNs. Employers, insurers, third party administrators, etc. will be asked for EINs. To confirm that this ALERT is an official Government document and for further information on the mandatory reporting requirements under this law, please visit the CMS website at www.cms.hhs.gov/MandatoryInsRep.
The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a "conditional payment" so as not to inconvenience the beneficiary, and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. This reporting is to assist CMS and other insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

We are asking you to answer the questions below so that we may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.

Section I

Are you presently, or have you ever been, enrolled in Medicare Part A or Part B?  □ Yes  □ No

If yes, please complete the following; if no, proceed to Section II.

Full Name: (Please print the name exactly as it appears on your SSN or Medicare card if available)

Medicare Claim Number:  Date of Birth (Mo/Day/Year)

Social Security Number: (If Medicare Claim Number is Unavailable)

Sex  □ Female  □ Male

Section II

I understand that the information requested is to assist the requesting insurance arrangement to accurately coordinate benefits with Medicare and to meet its mandatory reporting obligations under Medicare law.

Claimant Name (Please Print)  Claim Number

Name of Person Completing This Form If Claimant is Unable (Please Print)

Signature of Person Completing This Form  Date

If you have completed Sections I and II above, stop here. If you are refusing to provide the information requested in Sections I and II, proceed to Section III.
Section III

Claimant Name (Please Print) ____________________________ Claim Number ____________________________

For the reason(s) listed below, I have not provided the information requested. I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

Reason(s) for Refusal to Provide Requested Information:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature of Person Completing This Form ____________________________ Date ____________________________