Application for Compensation in *United States v. Magellan Diagnostics, Inc., USDC, Dist. Of Mass., 24 CR 10144*

As part of a settlement with the U.S. Department of Justice (DOJ), Magellan Diagnostics, Inc. ("Magellan") agreed to compensate eligible patients and legal guardians of patients who were harmed because a malfunction in certain Magellan lead testing devices caused the devices to report falsely low levels of lead in venous blood (blood taken from a vein, not a finger/heel stick) from June 27, 2013, to May 31, 2017 ("Relevant Period").

By submitting this application, you are claiming that you and/or a minor child legally under your care were harmed by the delayed detection of lead exposure due to the malfunction in Magellan's lead testing devices sometime during the Relevant Period. Your application will be reviewed to determine if you qualify to receive compensation for the damage that Magellan caused. Please note, monetary damages would include such things as lost wages or medical bills and other damages that can be measured in terms of money. Other types of damage – like pain and suffering or diminished quality of life – are not the types of harm covered under the settlement. Attorneys' fees are also not recoverable from the fund.

An independent monitor, Guidepost Solutions, will review your application for compensation and determine whether each applicant meets the following eligibility requirements:

- The applicant received a blood lead test using a Magellan LeadCare® device in the Relevant Period;
- The applicant's blood was taken from a vein (as opposed to a capillary draw from a finger stick or heel stick);
- The applicant's test results did not indicate a level of lead in the blood that would require further medical care (i.e., a "low" level of lead at the time the test was given);
- The applicant had a subsequent blood lead test that indicated a blood lead level that was higher than the first test, or there is other contemporaneous evidence to establish that the result of the Magellan venous test was falsely low; and
- The applicant had expenses, costs, or other monetary harm because of an inaccurate test that caused a delay in the diagnosis or treatment of an elevated blood lead level.

If the Monitor determines that you and/or your minor children may be eligible for compensation, the Monitor will send you a claim form requesting details about the harm you suffered and any supporting documentation that is available. The Monitor will make a recommendation to the DOJ, which will then make the final decision on whether you qualify for compensation, and how much you may receive. The decision will be made solely by the DOJ, not the Monitor or Magellan. The DOJ's decisions whether you qualify for compensation under this fund and/or the amount of compensation are final and cannot be appealed by you.

The application requires that you answer certain questions and provide supporting documents when available. This application will be kept confidential as required by law.

We recommend submitting your application before June 30, 2026. You can submit electronically or by mail. The final deadline for submission of all claims is January 6, 2027.

If you have any questions about this process, you may consult the Monitor website at www.MagellanDxmonitor.com.

Note: The information submitted in this application, including all attachments, will remain confidential and in the custody of the Monitor, except to the extent that it may be shared as necessary to investigate or validate your claim.

Person Submitting This Application (Required Fields):

Note: For the person submitting this application, as well as for each adult applicant, some form of identification must be uploaded. Acceptable forms of identification include, but are not limited to the following:

- Photo identification (ex. driver's license, passport (U.S. or non-U.S.), non-U.S. photo ID.)
- Insurance identification card
- Medicaid/Medicare card
- Birth certificate
- Federal, state, or local public benefit identification card
- Work or school identification card
- Public library card
- Voter registration card
- Social security card

First Name: _____ Middle Name: _____ Last Name: _____

Form of ID Submitted: _____

Date of Birth (Month/Date/Year): _____

Current address:

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Previous address:

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Preferred phone number: _____

Is this a mobile phone:

Yes ☐ No ☐

Email address: _____

Other Identification Information (Required Fields):

I am submitting this application on behalf of: (check one)

Myself ☐

My child/minor dependent(s) ☐

Both myself and my child/minor dependent(s) ☐

Information For Each Applicant (Required Fields for each Applicant/Minor Child):

Applicant 1:

First Name: _____ Middle Name: _____ Last Name: _____

Form of ID Submitted: _____

Current address (if different):

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Address at the time of the initial blood lead test during the Relevant Period (if different from above)

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Applicant's date of birth (Month/Date/Year): _____

Applicant's gender: _____

Did the Applicant receive a blood lead test or tests between January 2013 and May 2017?

Yes ☐ No ☐

Was a Magellan LeadCare device used to conduct the blood lead test?

Yes ☐ No ☐ I don't know ☐

If Yes, how do you know?

_____

_____

_____

_____

Was the Applicant's blood taken from a vein (as opposed to a capillary draw from a finger stick or heel stick)?

Yes ☐ No ☐ I don't know ☐

Was the Applicant tested again after the initial blood lead test?

Yes ☐ No ☐ I don't know ☐

Was the second blood lead test result higher?

Yes ☐ No ☐

Did the applicant have expenses, costs, or other monetary harm because of a delay in the diagnosis or treatment of an elevated blood lead level?

Yes ☐ No ☐

Blood Lead Testing History

Please list the **date**, **location** (doctor's office, hospital, urgent care, clinic, etc.), and **result** (µg/dL) of every blood lead test administered to the applicant. If you do not know the date, please use an approximate date, and write unknown if you do not currently have a particular part of the requested information, such as the result of the test. If known, please provide the names of any physicians or other medical professionals who ordered or administered each blood test. Include office addresses and any contact information.

Example: 01/01/2014, Dr. Smith's office 123 Oak Lane, Clinton, NJ 12345, 2 micrograms per deciliter (µg/dL)

1. Date:_____

   Location Name: _____

   Street 1: _____

   Street 2: _____

   City: _____ State: _____ Zip: _____

   Country: _____

   Result: _____

2. Date:_____

   Location Name: _____

   Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

3. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

4. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

5. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

PLEASE UPLOAD ANY DOCUMENTS YOU HAVE RELATING TO BLOOD LEAD TEST RESULTS

Applicant 2 (if applicable):

First Name: _____ Middle Name: _____ Last Name: _____

Form of ID Submitted: _____

Current address (if different):

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Address at the time of the initial blood lead test during the Relevant Period (if different from above)

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Applicant's date of birth (Month/Date/Year): _____

Applicant's gender: _____

Did the Applicant receive a blood lead test or tests between January 2013 and May 2017?

Yes ☐ No ☐

Was a Magellan LeadCare device used to conduct the blood lead test?

Yes ☐ No ☐ I don't know ☐

If Yes, how do you know?

_____

_____

_____

_____

Was the Applicant's blood taken from a vein (as opposed to a capillary draw from a finger stick or heel stick)?

Yes ☐ No ☐ I don't know ☐

Was the Applicant tested again after the initial blood lead test?

Yes ☐ No ☐ I don't know ☐

Was the second blood lead test result higher?

Yes ☐ No ☐

Did the applicant have expenses, costs, or other monetary harm because of a delay in the diagnosis or treatment of an elevated blood lead level?

Yes ☐ No ☐

Blood Lead Testing History

Please list the **date**, **location** (doctor's office, hospital, urgent care, clinic, etc.), and **result** (µg/dL) of every blood lead test administered to the applicant. If you do not know the date, please use an approximate date, and write unknown if you do not currently have a particular part of the requested information, such as the result of the test. If known, please provide the names of any physicians or other medical professionals who ordered or administered each blood test. Include office addresses and any contact information.

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1. Date:_____

   Location Name: _____

   Street 1: _____

   Street 2: _____

   City: _____ State: _____ Zip: _____

   Country: _____

   Result: _____

2. Date:_____

   Location Name: _____

   Street 1: _____

   Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

3. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

4. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

5. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

PLEASE UPLOAD ANY DOCUMENTS YOU HAVE RELATING TO BLOOD LEAD TEST RESULTS

Applicant 3 (if applicable):

First Name: _____ Middle Name: _____ Last Name: _____

Form of ID Submitted: _____

Current address (if different):

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Address at the time of the initial blood lead test during the Relevant Period (if different from above)

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Applicant's date of birth (Month/Date/Year): _____

Applicant's gender: _____

Did the Applicant receive a blood lead test or tests between January 2013 and May 2017?

Yes ☐ No ☐

Was a Magellan LeadCare device used to conduct the blood lead test?

Yes ☐ No ☐ I don't know ☐

If Yes, how do you know?

_____

_____

_____

_____

Was the Applicant's blood taken from a vein (as opposed to a capillary draw from a finger stick or heel stick)?

Yes ☐ No ☐ I don't know ☐

Was the Applicant tested again after the initial blood lead test?

Yes ☐ No ☐ I don't know ☐

Was the second blood lead test result higher?

Yes ☐ No ☐

Did the applicant have expenses, costs, or other monetary harm because of a delay in the diagnosis or treatment of an elevated blood lead level?

Yes ☐ No ☐

Blood Lead Testing History

Please list the **date**, **location** (doctor's office, hospital, urgent care, clinic, etc.), and **result** (µg/dL) of every blood lead test administered to the applicant. If you do not know the date, please use an approximate date, and write unknown if you do not currently have a particular part of the requested information, such as the result of the test. If known, please provide the names of any physicians or other medical professionals who ordered or administered each blood test. Include office addresses and any contact information.

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1. Date:_____

   Location Name: _____

   Street 1: _____

   Street 2: _____

   City: _____ State: _____ Zip: _____

   Country: _____

   Result: _____

2. Date:_____

   Location Name: _____

   Street 1: _____

   Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

3. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

4. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

5. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

PLEASE UPLOAD ANY DOCUMENTS YOU HAVE RELATING TO BLOOD LEAD TEST RESULTS

Applicant 4 (if applicable):

First Name: _____ Middle Name: _____ Last Name: _____

Form of ID Submitted: _____

Current address (if different):

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Address at the time of the initial blood lead test during the Relevant Period (if different from above)

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Applicant's date of birth (Month/Date/Year): _____

Applicant's gender: _____

Did the Applicant receive a blood lead test or tests between January 2013 and May 2017?

Yes ☐ No ☐

Was a Magellan LeadCare device used to conduct the blood lead test?

Yes ☐ No ☐ I don't know ☐

If Yes, how do you know?

_____

_____

_____

_____

Was the Applicant's blood taken from a vein (as opposed to a capillary draw from a finger stick or heel stick)?

Yes ☐ No ☐ I don't know ☐

Was the Applicant tested again after the initial blood lead test?

Yes ☐ No ☐ I don't know ☐

Was the second blood lead test result higher?

Yes ☐ No ☐

Did the applicant have expenses, costs, or other monetary harm because of a delay in the diagnosis or treatment of an elevated blood lead level?

Yes ☐ No ☐

Blood Lead Testing History

Please list the **date**, **location** (doctor's office, hospital, urgent care, clinic, etc.), and **result** (µg/dL) of every blood lead test administered to the applicant. If you do not know the date, please use an approximate date, and write unknown if you do not currently have a particular part of the requested information, such as the result of the test. If known, please provide the names of any physicians or other medical professionals who ordered or administered each blood test. Include office addresses and any contact information.

Example: 01/01/2014, Dr. Smith's office 123 Oak Lane, Clinton, NJ 12345, 2 micrograms per deciliter (µg/dL)

1. Date:_____

   Location Name: _____

   Street 1: _____

   Street 2: _____

   City: _____ State: _____ Zip: _____

   Country: _____

   Result: _____

2. Date:_____

   Location Name: _____

   Street 1: _____

   Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

3. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

4. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

5. Date:_____

Location Name: _____

Street 1: _____

Street 2: _____

City: _____ State: _____ Zip: _____

Country: _____

Result: _____

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If you have additional Applicant(s) beyond the four for which space was provided, please indicate the number of additional applicants and provide each of their names:

_____

_____

_____

_____

Certification and Signature

The information provided by me in this application is true and accurate. I understand that as part of the decision-making process for my claim, this application will be shared with the federal government, and that false statements to a federal agency are prohibited by federal law and could subject me to prosecution or other liability.

SIGNATURE/ELECTRONIC SIGNATURE

Print Name

Date