EXHIBIT B1

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In Re Flint Water Cases

No. 5:16-cv-10444-JEL-MKM

HON. JUDITH E. LEVY

MAG. MONA K. MAJZOUB

EXHIBIT 5

Flint Water Settlement Registration Form

VERIFIED REGISTRATION FORM

The instructions below explain the form and documents that you must submit to be eligible to later assert a claim for compensation from the Flint water cases Qualified Settlement Fund.

PLEASE CAREFULLY READ ALL THE INSTRUCTIONS BEFORE SUBMITTING YOUR REGISTRATION

1. INSTRUCTIONS AND REGISTRATION CRITERIA

You must submit this completed and signed Verified Registration Form and provide the supporting documentation mentioned in this form or its attachment ("Registration").

The **deadline to Register** is [INSERT DATE]. For paper submissions, this deadline is determined by the date your return envelope is postmarked. You can also complete the Registration Form online: officialflintwatersettlement.com. You must complete all applicable blanks in this form.

- By signing this Registration Form, you attest that you as the "Registrant" (or if you are filling out this form for someone else, that they as the "Registrant") are claiming or could claim personal injury, property damage, business economic loss, unjust enrichment, breach of contract, or any other type of damage or relief due to, and fit into, at least one of the following descriptions (check all that apply to you):
  - ☐ Registrant owned or lived in a residence served by the Flint Water Treatment Plant (FWTP), or was legally liable for the payment of bills for such water, during the period April 25, 2014 to November 16~~—~~, 2020.
  - ☐ Registrant owned or operated a business served by the FWTP, or was legally liable for the payment of bills for such water, during the period April 25, 2014 to November 16~~—~~, 2020.
  - ☐ Registrant was exposed to water from the FWTP for at least 21 days during any 30-day period between April 25, 2014 and November 16~~—~~, 2020.
  - ☐ During the period April 25, 2014 through December 31, 2018, Registrant was both exposed to water from the FWTP and diagnosed with Legionnaires' Disease.

After you submit this Registration Form, the Claims Administrator will send you a Claim Form if you are eligible to make a claim from the Settlement. That later Claim Form will explain the documents and other information that you will need to submit at that time. The Claim Form will allow you to pick one or more of 30 possible claim categories. To receive a payment you will need to provide the supporting information for the claim category or categories you select. Your R~~r~~egistration alone does not guarantee that you will receive a payment. You can find more information on the supporting documents and information that will be required at that later stage for each of the 30 possible categories at officialflintwatersettlement.com.

2. REGISTRANT INFORMATION

In this section, fill in the information about the person who is registering for the settlement. If you are submitting this form for yourself, then you are the "Registrant." Each person or entity must fill out his, her or its own Registration Form.

In this section, if you are submitting this form on behalf of a person who is deceased, legally incapacitated, or a minor, fill in the information about that deceased, legally incapacitated or minor person. That person is the "Registrant" for the purpose of this section. If you are filling out this form for a deceased, legally incapacitated, or minor person, then you must also fill out section 3 of this form and provide the information described there.

Registrant Name	Last	First	Middle
Social Security Number of Registrant	☐☐☐■☐☐■☐☐☐☐	**Date of Birth of Registrant** ___/___/_____(Month/Day/Year)	
Current Address of Registrant	Street/P.O. Box		Apt./Suite
	City	State	Zip
	Dates resided at this address:	From	To
All other Registrant addresses since April 25, 2014 (if not the same as current address)	Street/P.O. Box		Apt./Suite
	City	State	Zip
	Dates resided at this address:	From	To
Addresses (if more than one address during relevant time period). If you had additional addresses during this time period, please attach sheet with address information.	Street/P.O. Box		Apt./Suite
	City	State	Zip
	Dates resided at this address:	From	To

Registrant's Contact Information. If Registrant is a deceased, minor, or legally incapacitated person, do not fill in this contact information section. Instead, put your contact information in section 3 below.	Phone	☐ Work ☐ Mobile ☐ Home
	Alt. Phone	☐ Work ☐ Mobile ☐ Home
	Email	

3. NEXT FRIEND, PERSONAL REPRESENTATIVE, OR GUARDIAN INFORMATION
(Fill out this section only if you are submitting this form on behalf of a minor, legally incapacitated, or deceased person)

Is this registration being made by a Next Friend or court-appointed personal representative or guardian on behalf of a minor, legally incapacitated, or deceased person?

YES ☐ NO ☐

If Yes, **complete this section 3.**

Relationship to Registrant Attach documents proving that you have the relationship to, or the legal appointment for, the Registrant in the box(es) you check. Please review the attached chart that shows the documents you will need to submit. You must also provide notice to the Registrant's other relatives or court-appointed representatives listed that you are submitting this registration for the Registrant. For example, if you are the Registrant's sibling, you must notify Registrant's other siblings, parents, aunts, uncles, spouse, children, grandparents, and court-appointed representatives (if any are applicable) that you are registering for the Registrant.	**Check all that apply:** ☐ Spouse ☐ Parent ☐ Stepparent ☐ Adult Child ☐ Adult Sibling ☐ Adult Aunt ☐ Adult Uncle ☐ Grandparent ☐ Legal Guardian or other court appointed representative ☐ Estate Administrator ☐ Other (specify):

Representative's Name	Last	First	Middle
Representative's Address	Street/P.O. Box		Apt./Suite
	City	State	Zip
Representative's Social Security Number	☐☐☐■☐☐■☐☐☐☐	**Representative's Date of Birth**	___/___/___ (Month/Day/Year)
Date of Death of Registrant (if applicable)	___/___/___ (Month/Day/Year)		

Representative's Contact Information	Phone	☐ Work ☐ Mobile ☐ Home
	Alt. Phone	☐ Work ☐ Mobile ☐ Home
	Email	

4. ATTORNEY INFORMATION			
Did you hire an attorney to represent or assist you? **YES ☐** **NO ☐**			
If Yes, **complete this section 4.**			
Attorney's Name	Last	First	
Firm Name	Law Firm		
Address	Street		
	City	State	Zip
Phone and Email	Phone	Email	

5. DOCUMENT REQUIREMENTS	
To register, you must submit the following documents to ARCHER Systems, LLC either in the return envelope provided if you received this form in the mail, or complete the Registration Form and upload the supporting documents by going to the website and following the links at: officialflintwatersettlement.com:	
☐	This Completed and Signed Registration Form, and attached Authorization to ~~MDHHS to~~ Disclose Blood Lead Test Result Data to MDHHS if Registrant intends to make a personal injury claim. MDHHS Authorization is optional for Registrant to sign. However, such Authorization is the only way that MDHHS can provide Registrant's blood lead level test results to the Settlement Claims Administrator to assist with Registrant's future claim~~.~~
☐	Copy of identification document, such as your State-issued ID card, driver's license, birth certificate, or similar document, unless counsel for Registrant/Next Friend signs and verifies this Registration Form with permission of such Registrant/Next Friend~~.~~
☐	Any documents required if you filled out section 3 of this form for a minor, legally incapacitated or deceased person.

6. VERIFICATION				
I certify and attest under penalty of perjury, pursuant to 28 U.S.C. Section 1746, that: I am 18 years of age or older; the Registrant meets the eligibility criteria above in section 1; all information submitted in support of this registration, including the information contained within and submitted with this Registration Form, is true, correct, accurate, and complete to the best of my knowledge; and, if I completed section 3 above, I have notified all persons who have the identified relationship with the Registrant and who might qualify to act as a Next Friend for the Registrant, that I am submitting this Registration Form on behalf of the Registrant and none of those individuals have advised me of any objection. I understand that false statements or claims made in connection with this Registration Form may result in fines, imprisonment, and/or any other remedy available by law.				
Registrant's or Representative's Signature			**DATE**	_____/____/_____ (month) (day) (year)
Printed Name	First	MI	Last	

Instructions to complete this form are attached. ~~**An instruction form to help complete this Registration Form will be filed with the Court and provided separately as a supplemental exhibit, or as part of a replacement exhibit for this Registration Form.**~~

AUTHORIZATION TO DISCLOSE BLOOD LEAD TEST RESULT DATA:

Michigan Department of Health and Human Services

Directions: *Type or Print all requested information, with exception of signatures on Page 2.*

Individual's Name (Beneficiary, Recipient, Patient, Consumer, etc.)			Individual's Gender
Street Address			Individual's Date of Birth / /
City	State	ZIP Code	Phone ( ) -

I AUTHORIZE THE MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS) TO SHARE MY HEALTH INFORMATION:

ALL BLOOD LEAD TEST RESULTS ON RECORD AFTER APRIL 1, 2014

MDHHS MAY SHARE MY HEALTH INFORMATION WITH THE FOLLOWING PERSON OR ORGANIZATION:

Name of Person/Organization

Street Address

City, State, ZIP Code

( ) - ( ) -

Phone Number Fax Number

MDHHS WILL SHARE MY BLOOD LEAD TEST RESULTS FOR THE FOLLOWING REASON:

Blood lead test results will be shared with the Claims Administrator to provide proof of blood lead tests for the purpose of making a claim for compensation in the Flint Water Settlement.

BY SIGNING THIS FORM, I UNDERSTAND THAT:

- I do not have to sign this authorization.
- MDHHS Childhood Lead Poisoning Prevention Program will search the blood lead tables based off Name, Date of Birth and Gender provided with this release. The blood lead data tables contain the test result and patient information as reported by the testing facility, unless updated based off of additional resources.
- Other types of information shared under this authorization may be re-disclosed by the person or organization I identified above and may no longer be protected by federal or state law.
- I may change my mind and revoke (take back) this authorization at any time. To revoke this authorization, write to the MDHHS program that maintains your records and include a copy of the front of this form.
- Information that has already been shared based on this authorization cannot be taken back.
- I may request a copy of this signed authorization. If I have not previously revoked this authorization, it will expire on: *(list a date, event or condition)*

_____

Date, Event or Condition
(Authorization will expire one year from the signature date if you leave this section blank.)

Signature of Individual or Legal Representative	Date / /
Name of Individual or Legal Representative	
Legal Representative's Relationship to Individual (i.e., Parent, Guardian, Patient Advocate, Authorized Representative, Power of Attorney. Documentation may be required.)	

MDHHS USE ONLY

This authorization was revoked: / /	
Signature	Date

COMPLETION: Is voluntary but required if disclosure is requested.

Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs, or disability.