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NAMSA®

SYNTACTX

Valiant Navion™ Thoracic Stent Graft System

SAFE-N REIMBURSEMENT PROGRAM

Authorization for Patient Caregiver

For SAFE-N Patient and Physician Support Program

Please complete and sign the form and submit to Syntactx/NAMSA. For any questions in completing this verification form, please contact Medtronic through Syntactx/NAMSA at the SAFE-N reimbursement helpline: 00080005 02426 or email: SAFE-N-Reimburse@syntactx.com.

Patient Full Name: _____

Patient Address: _____

City: _____ State: _____ Pin Code: _____

Aadhaar Number:

Caregiver Authorization Statement

I, _____, am the patient identified above that has been implanted with the Valiant Navion™ Thoracic Stent Graft System and am eligible for participation in the SAFE-N Reimbursment Program ("Program"). I certify that I have chosen and hereby authorize,_____, who is my _____, ("Caregiver") to contact the Program sponsors and administrators on my behalf. For purposes of this Authorization, Caregiver may be a family member or non-family member I have authorized to assist me with this Program.

For purposes of participating in this Program, I authorize my Caregiver to disclose my patient records (which may include my full name, address, date of birth, email address, medical diagnosis, and billing records) and other Sensitive Health Information to Syntactx/NAMSA.

I understand that I may revoke this authorization in writing at any time. Any revocation must be submitted in writing to Syntactx/NAMSA. This Authorization too shall expire one year after my date of death, unless I choose

to revoke this authorization at an earlier date. I understand that any revocation will affect only future disclosures, not any disclosures made before Syntactx/NAMSA receives my written revocation.

I understand that my treatment, payment, enrollment, eligibility for, or receipt of support from Syntactx/NAMSA is not conditioned on whether I sign this authorization.

I understand that the Program is voluntary and is not intended to be an admission of liability of any kind or a waiver by individuals participating in the Program.

I certify that the statements and information contained herein or provided in this document are true, accurate, and complete. By signing this authorization, I acknowledge that I have read and accept all of the above, and that I have been provided with a copy of this signed authorization.

Patient Signature: _____ Date: _____

Patient Caregiver Information

Patient Caregiver Full Name: _____

Patient Caregiver Email Address: _____

Patient Caregiver Address: _____

City: _____ State: _____ Pin code: _____

Aadhaar Number: