CLAIM FORM

Quebec DePuy ASR Hip Implant Class Action

This form and all supporting documents must be completed and submitted to the Claims Administrator by **no later than May 24, 2019, either by email, telecopier or by mail (indicating the date of transmission), to the following coordinates:**

COLLECTIVA
2170 Boulevard René Lévesque O, Suite 200
Montreal (Quebec) H3H 2T8
Telecopier: 514-287-1617
Email: depuyasr@collectiva.ca

FAILURE TO SUBMIT YOUR CLAIM FORM BY THE DEADLINE WILL LEAD TO THE AUTOMATIC DISMISSAL OF YOUR CLAIM.

I am making a claim:

☐ as a Claimant who was implanted with one or more ASR Implants.

☐ as the Representative (a person who is the legal representative of a Claimant who is deceased or under a legal disability) of a Claimant.

Section A: Claimant Information

First Name | Middle | Last Name

Date of Birth (mm/dd/yyyy) | Gender: ☐ Male ☐ Female

Address

City | Province/Territory | Postal Code

Daytime Phone Number | Cellular Phone Number

Email | Current Provincial Health Insurance Number

Section B: Residential address

Did the Claimant have his/her principal residence in Quebec at the following times?

1. When he/she underwent hip surgery, at which time an ASR Implant was inserted ("Initial ASR Surgery")? ☐ Yes ☐ No

2. If applicable, when he/she underwent surgery to replace the cup or any component of an ASR Implant ("Revision Surgery")? ☐ Yes ☐ No

3. On August 24, 2010 (at the time of the Recall of the ASR Implants)? ☐ Yes ☐ No

Did the Claimant have his/her principal residence outside of Canada on April 3, 2018?

☐ Yes ☐ No

If "Yes", did the Claimant undergo Initial ASR Surgery or Revision Surgery in Quebec?

☐ Yes ☐ No

Section C: Personal Representative

Are you completing this form as someone with the legal capacity to act on behalf of the Claimant (*i.e*., an individual with power of attorney, an estate representative, etc.)?

☐ Yes ☐ No

If you checked “No”, please skip to Section D.

If you checked “Yes”, please complete the remainder of Section C with information about yourself.

First Name | Middle | Last Name

Date of Birth (mm/dd/yyyy)

Address

City | Province/Territory | Postal Code

Email | Date of death of the Claimant (if applicable) (mm/dd/yyyy)

Daytime Phone Number | Cellular Phone Number

Relationship to Claimant:

Please attach to this Claim Form the documents that grant you the legal authority to act on behalf of the Claimant (i.e. Power of Attorney, Last Will and Testament, Letters of Administration, etc.). If the Claimant is deceased, please also attach a copy of the Claimant's death certificate to this form.

☐ Power of Attorney ☐ Certificate of Incapacity ☐ Grant of Probate

☐ Will ☐ Death Certificate

☐ Other. Please explain _____

Section D: ASR Implant Information

In which hip(s) did you receive an ASR Implant? ☐ Right ☐ Left ☐ Bilateral

Date of Initial ASR Surgery (Right) _____ (mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

Date of Initial ASR Surgery (Left) _____ (mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

If you also received an ASR Implant during a Revision Surgery, please indicate which hip, as well as the surgery date, the name of the Hospital and the name of the Surgeon

_____

Operative report(s) for your Initial ASR Surgery / Initial ASR Surgeries, Identification Labels/stickers confirming receipt of the ASR Implant(s), and hospitalization summary sheets for your Initial ASR Surgery / Initial ASR Surgeries must be submitted with this Claim Form.

Section E: Revision Information

Has the Claimant undergone Revision Surgery or Revision Surgeries to replace the ASR Implant(s)?

☐ Yes ☐ No

If you checked “No”, please skip to Section F.

If you checked “Yes”, please indicate which hip(s) underwent Revision Surgery:

☐ Right ☐ Left ☐ Bilateral

Revision Surgery Date (Right) _____ (mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

Revision Surgery Date (Left) _____ (mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

Operative report(s) and hospitalization summary sheets for your Revision Surgery / Revision Surgeries must be submitted with this Claim Form.

Section F: Revision Medically Contraindicated

Has the Claimant's surgeon recommended a Revision Surgery, but also advised the Claimant that a Revision Surgery is medically contraindicated and/or would be life threatening?

☐ Yes ☐ No

If you checked "No", please skip to Section G.

If you checked "Yes", what was the specific reason given as to why the Claimant was medically unable to undergo Revision Surgery.

_____

_____

_____

You must submit medical records confirming the surgeon's determination that a Revision Surgery was medically necessary, but that Revision Surgery was medically contraindicated and/or would be life threatening.

Section G: Re-Revision Information

Has the Claimant undergone Re-Revision Surgery / Re-Revision Surgeries to replace the artificial implant inserted during Revision Surgery?

☐ Yes ☐ No

If you checked “No”, please skip to Section H.

If you checked “Yes”, when did the Claimant undergo Re-Revision Surgery / Re-Revision Surgeries?

_____
dd/mm/yyyy

At what hospital(s) and who was/were the surgeon(s) who performed the Re-Revision Surgery / Re-Revision Surgeries?

_____

Which hip(s) underwent Re-Revision Surgery?

☐ Right ☐ Left ☐ Bilateral

Operative report(s) and hospitalization summary sheets for all Re-Revision Surgeries must be submitted with this Claim Form.

Section H: Extraordinary Medical Complications

Following Revision Surgery or Re-Revision Surgery, did the Claimant experience any of the following Extraordinary Medical Complications?

If so, state the date on which the complication(s) occurred.

If not, please skip to Section I below.

	Date (mm/dd/yyyy)
A stroke	_____
A heart attack	_____
A pulmonary embolism	_____
Death	_____
A femoral nerve palsy	_____
A foot drop	_____
A luxation/dislocation requiring a closed reduction medical procedure	_____
Was not able to return to work for a period greater than one (1) year as a result of medical problems associated with Revision Surgery or Re-Revision Surgery	_____

If you experienced any of the above Extraordinary Medical Complications, you must submit medical records associated with the Extraordinary Medical Complication(s) and/or a letter/declaration of invalidity from the Claimant's treating physician stating that the Claimant is or was not able to return to work for a period greater than one (1) year as a result of medical problems associated with Revision Surgery or Re-Revision Surgery.

Section I: Claimants who have not undergone Revision Surgery

Has it been 11 years or more since the Claimant underwent Initial ASR Surgery, and the Claimant has not undergone Revision Surgery?

☐ Yes. Please skip to Section J below.

☐ No. I have not undergone Revision Surgery, but my Initial ASR Surgery was less than 11 years ago.

If you checked "No", you must elect **one** of the following options:

☐ (a) I wish to receive Unrevised Claimant Compensation of $2,500.00 within 60 days of approval of my claim, and I renounce my right to any further compensation even if I undergo Revision Surgery within 11 years of Initial ASR Surgery; or

☐ (b) I wish to remain eligible for Revision Surgery Compensation if I undergo medically necessary Revision Surgery within 11 years of Initial ASR Surgery, and I renounce my right to receive Unrevised Claimant Compensation of $2,500.00, even if I do not end up needing Revision Surgery within 11 years of Initial ASR Surgery.

You are strongly urged to consult your orthopaedic surgeon about the likelihood of you needing to undergo medically necessary Revision Surgery within 11 years of Initial ASR Surgery before making the above choice.

Section J: Mailing address for compensation

If you are approved and are entitled to receive compensation you will receive 1 cheque if you are approved as an Unrevised Claimant, and you will receive 3 Distribution cheques if you are approved as a Revised Claimant.

Would you like your cheque(s) to be delivered to a different address than that indicated in Section A?

If “No”, all of your Distribution cheques will be delivered to the address indicated in Section A, unless you notify the Claims Administrator in writing of a change of address.

If “Yes”, please provide address below:

Address

City | Province/Territory | Postal Code

Section K: Declaration

I solemnly declare that:

The Claimant was implanted with one or more ASR Implants.

The Claimant wishes to make a claim for compensation in this class action.

Attached are copies of required documentation, including Medical Records confirming the Claimant's receipt of ASR Implant(s) during Initial ASR Surgery, as well as Medical Records confirming the Claimant's Revision Surgeries, if applicable, Re-Revision Surgeries, if applicable, and Extraordinary Medical Complications, if applicable. Also attached are Labels identifying the catalogue and lot numbers of the ASR Implants received by the Claimant.

If I am not submitting the Claimant's ASR Implant Labels, it is because the hospital at which the Claimant's Initial ASR Surgery / Initial ASR Surgeries occurred could not provide me with the Labels because they are not in the Claimant's hospital medical records. As a result, I am attaching a letter from the Claimant's orthopedic surgeon confirming that the Claimant in fact received ASR Implant(s) during Initial ASR Surgery.

I make this declaration believing it to be true, and knowing that it is of the same legal force and effect as if it were made under oath.

_____ _____

Signature of Claimant or Representative Date

We strongly recommend that you keep a photocopy of your complete claim for your records.