SCHEDULE A – CLAIM FORM AND CLAIMANT DECLARATION

DEPUY BC ASR REVISION CLASS SETTLEMENT

This form must be completed and returned to the Claims Administrator by email, mail, fax or in person no later than **5:00 pm Vancouver time on October 25, 2021**

I am making a claim either myself or through counsel:

☐ as an Eligible Claimant who was implanted with ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System.

☐ as the Representative (a person who is the legal representative of an Eligible Claimant who is deceased or under a legal disability) of an Eligible 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 ("PHN")

Did the Claimant's province of residence change since the time that the Claimant received the ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System?

☐ Yes ☐ No

If you checked "Yes," please list the Claimant's other province(s) of residence, the date range in which the Claimant lived in each other province, and his/her Provincial Health Insurance Number(S) for those province(s):

Section B: 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 "Yes," please complete the remainder of Section B with information about yourself. If "No," skip to Section C.

First Name | Middle | Last Name

Date of Birth (mm/dd/yyyy)

Address

City | Province/Territory | Postal Code

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

Daytime Phone Number | Cellular Phone Number

Relationship to Claimant:

Please attach the documents that grant you the legal authority to act on behalf of the Claimant to this form (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
☐ Letters of Administration
☐ Will
☐ Death Certificate
☐ Grant of Probate
☐ Other. Please explain

Section C: Lawyer Information (if applicable)

Lawyer Last Name Lawyer First Name

Name of Law Firm

Address

Phone Number Email

Please include any Direction to Pay, if applicable.

Section D: ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System Implant Information ("ASR Implant")

Location of the ASR Implant: □ Right □ Left □ Bilateral

ASR Implant Date (Right) _____
(mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

ASR Implant Date (Left) _____
(mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

Identification stickers and Contemporaneous Medical/Hospital Records for your ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System must be submitted with this Claimant Declaration.

Please attach:

□ Product Identification Stickers

□ For ASR Index Surgery, Medical History and Physical, Discharge Summaries, and Operative Reports

□ For ASR Revision Surgery, Medical History and Physical, Discharge Summaries, and Operative Reports

- ☐ For Complications, Medical History and Physical, Discharge Summaries, and Operative Reports
- ☐ If Product Identification Stickers are not available, please provide evidence of efforts to obtain. Contemporaneous Medical/Hospital Records may be provided as evidence of product use if product identification stickers are unavailable.
- ☐ If Contemporaneous Medical/Hospital Records are not available, please provide evidence of efforts to obtain. A Physicians Declaration from a treating physician may be provided if Contemporaneous Medical/Hospital Records are unavailable.

Section E: Revision Information

Has the Claimant undergone a revision surgery or surgeries to remove the cup of the ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System?

☐ Yes ☐ No

If you checked "No," please skip to Section F below.

Location of Revision: ☐ Right ☐ Left ☐ Bilateral

ASR Implant Revision Date (Right) _____
(mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

ASR Implant Revision Date (Left) _____
(mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

Section F: Revision Scheduled But Has Not Occurred

Has the Claimant's doctor recommended and scheduled an ASR Revision Surgery that has not yet taken place?

☐ Yes ☐ No

If you checked "Yes," you must submit a Physician's Declaration (Schedule D) completed and signed by your physician with this form and complete the remainder of Section F.

If you checked "No" because you have not had an ASR Revision Surgery and are not scheduled to have one, please skip to Section K.

Identify the name and address of the doctor who recommended and has scheduled a date for an ASR Revision Surgery for the Claimant, the date on which the physician made the surgery recommendation and scheduled it, and the date for which the ASR Revision Surgery is scheduled and where.

Date(s) of Surgery Recommendation (MM/DD/YYYY)

Doctor

Address

Medical Condition(s): _____

Date and place for
Which Surgery Is
Scheduled

Section G: Claimant's Spouse Information

If the Claimant had at least one ASR Revision Surgery to remove the cup of an ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System, please answer the following:

Did your spouse who was lawfully married to you and who lived with you in the same household at both the time (1) Claimant was implanted with an ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System, **AND** (2) Claimant underwent an ASR Revision Surgery to remove the cup of the ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System referred to in (1) above.

☐ Yes ☐ No

If you checked "Yes," list the spouse's name:

Name of Spouse

Section H: Post Revision Complications

Did the Claimant's revision surgery or surgeries cause any of the following? If so, state the date on which the complication occurred. (Please refer to Schedule H for definitions.)

	Date (mm/dd/yyyy)
Second Revision (Right)	_____
Second Revision (Left)	_____
Third Revision (Right)	_____
Third Revision (Left)	_____
Stroke	_____
Blood Clot	_____
Myocardial Infarction	_____
Infection	_____
Permanent peroneal nerve damage	_____
Death	_____

If you claimed above that the Claimant experienced and was diagnosed any of the listed Complications under the required circumstances (See Schedule H), you must submit Contemporaneous Medical/Hospital Records (as defined in Settlement Agreement) relating to each complication, with this form. If you are claiming any of the Complications for blood clot, infection, or permanent peroneal nerve damage, you also must submit a Physician Declaration.

Section I: Extraordinary Income Loss

Complete this section only if the Claimant had an ASR Revision Surgery and you are claiming Extraordinary Income Loss.

☐ Check here if as a result of an ASR Revision Surgery and Complication as defined on Schedule H, the Claimant incurred an extraordinary income loss that exceeded 20% of the aggregate annual income for the two years preceding the ASR Index Surgery.

☐ Check here if the Claimant was under 65 years of age when he or she incurred this Extraordinary Income Loss.

If you are claiming Extraordinary Income Loss, attach documentation substantiating all income during the two years preceding the Claimant's ASR Index Surgery and all income following the ASR Revision Surgery and income lost due to the ASR Revision Surgery and Complication. Include all tax papers pertaining to the income referred to above.

Amount claimed: _____ ☐ Supporting tax papers attached

Section J: Request for Re-imbursement of ASR Implant Purchase Cost

Complete this section only if the Claimant had an ASR Revision Surgery.

☐ Check here if the Claimant purchased his or her ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System implanted during the ASR Index Surgery and explanted during his or her ASR Revision Surgery with his or her own funds (*i.e.*, the cost of the implant was not paid by an insurer or reimbursed by anyone). If you checked the box, attach all receipts or other documentation reflecting the amount paid by the Claimant for the ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System to this form.

Section K: Declaration

I solemnly declare that:

The Claimant was implanted with one or more ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System.

The Claimant wishes to make a claim for compensation in this BC Class either as a BC Resident Opt-Out Subclass Member or as a Non-BC Resident Opt-In Subclass Member.

Attached are copies of the Claimant's implant surgery and revision surgery operative reports and documentation identifying the catalogue and lot numbers of the ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System.

Attached are Claimant's ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System peel-and-stick labels as product identification with this Claim Form. If these product labels are not available, you may include all other proof of product usage from your medical records and request a waiver through the Claims Administrator.

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

Please note: All pages of this Declaration and supporting documents must be submitted to the Claims Administrator on or before the Claims Deadline.