MFC CLAIM FORM AND CLAIMANT DECLARATION

DEPUY BC ASR CLASS SETTLEMENT

This Form is required for anyone who wishes to be considered for enhanced compensation pursuant to the "Most Favoured Class" ("MFC") clause in the Settlement Agreement.

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 May 27, 2022** (the "MFC Claims Deadline"), following which you have until June 27, 2022 to provide supporting Contemporaneous Medical/Hospital Records (as defined in Settlement Agreement) if required in support of your claim. Claims for enhanced compensation pursuant to the "Most Favoured Class" ("MFC") clause in the Settlement Agreement received after the MFC Claims Deadline will not be considered by the Claims Administrator.

Submitting this Form and providing the information requested does not mean you are entitled to receive enhanced compensation. A determination as to the availability, your eligibility and the amount of any enhanced compensation under the MFC clause will be made following the expiry of the MFC Claims Deadline and the 30 day deadline for providing supporting Contemporaneous Medical/Hospital Records (as defined in Settlement Agreement), where required.

BC Class members who have already submitted claims to the Claims Administrator must also complete this MFC Claim Form if they wish to make a claim for enhanced compensation.

Please check the BOXES which apply to you or the Class Member you represent:

A. I am making a claim either myself or through counsel:

   ❑ as a Class Member 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 a Class Member who is deceased or under a legal disability) Class Member.

B. Have you or the Class Member undergone a revision surgery of the ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System?

   ❑ Yes ❑ No

C. Have you or the Class Member already submitted a claim under the DEPUY BC ASR CLASS SETTLEMENT (the "Settlement")?

   ❑ Yes ❑ No

IF YOUR ANSWER TO QUESTION C IS 'YES', please complete ONLY sections A, B and C (if applicable), G and I below. Please note: if you or the Class Member have already submitted a claim under the Settlement, you are <u>not</u> required to resubmit your medical records unless you are relying on medical records that have not previously been submitted to support of your or the Class Member's request for consideration.

IF YOU ANSWERED "NO" TO QUESTION C above, you are required to complete all sections of this Form unless indicated and provide supporting Contemporaneous Medical/Hospital Records (as defined in Settlement Agreement) in support.

<u>CLAIMANT AND REPRESENTATIVE INFORMATION (Sections A, B, and C).</u>

Sections A must be completed by all claimants. If this Form is being submitted by a Personal Representative, please complete sections A, and B. If you are represented by a lawyer, please also complete Section C.

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 (if applicable)

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.

IMPLANT AND SURGERY INFORMATION (Sections D, E, F, and G)

If you have previously submitted a claim under the Settlement, DO NOT complete sections D, E, and F of this Form. Please proceed to Section G below.

If you have NOT previously submitted a claim under the Settlement, please complete sections D, E, F and G in accordance with the instructions below.

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 _____

If you have not previously submitted a claim, 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 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 (if applicable)

If you have not undergone revision surgery, please proceed to complete section F below. If you have undergone revision surgery, please complete the following information and then proceed to complete section G 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 Surgery Has Not Occurred (if applicable)

Complete this section only if you have not undergone revision of your ASR™ XL Acetabular Hip System or ASR™ Hip Resurfacing System.

_____

Doctor

_____

Address

Reason (check all that apply):

- ❑ I don't feel I need to be revised
- ❑ My doctor has not told me that I should have revision surgery
- ❑ My doctor has told me I should have a revision but that I have a serious medical condition which makes revision surgery too dangerous [date doctor said I should have revision _____]
- ❑ Other (explain):

_____
_____
_____
_____

** Attach all relevant Contemporaneous Medical/Hospital Records (as defined in Settlement Agreement).

Section G: Post Revision Complications (if applicable)

If you have previously submitted a claim under the Settlement, you are **not** required to resubmit your medical records. If you previously claimed compensation for a Post-Revision Complication, complete the chart below for only those complications which you experienced but for which no prior claim has been made.

If you have **not** previously submitted a claim under the Settlement and believe you have experienced a post revision complication(s) as set out below, please provide any Contemporaneous Medical/Hospital Records in support of your claim and complete the chart below.

Do not complete this section of the Form if you have **not** undergone revision surgery.

Did the Claimant's revision surgery or surgeries cause any of the following? If so, state the date on which the complication occurred.

	Date (mm/dd/yyyy)
Second Revision (Right)	_____
Second Revision (Left)	_____
Third Revision (Right)	_____
Third Revision (Left)	_____
Stroke	_____
Blood Clot	_____
Myocardial Infarction	_____
Infection	_____
A luxation/dislocation requiring a closed reduction medical procedure	_____
Permanent peroneal nerve damage	_____
Death	_____
Inability to Return to Work Post Revision (Greater than 1 Year)**	_____

**Attach proof of claim

Section I: Declaration

THIS DECLARATION MUST BE COMPLETED BY ALL CLAIMANTS AND REPRESENTATIVES COMPLETING THIS FORM

I solemnly declare that:

I/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 in accordance with the MFC Clause.

If not already submitted, attached are copies of my or 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.

If not already submitted, attached are my/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 Claim Form must be submitted to the Claims Administrator. Please note a failure to submit this Form within 30 days of April 27, 2022 will result in your claim being denied under the Settlement. Supporting documentation including Contemporaneous Medical/Hospital Records (as defined in Settlement Agreement) must be provided by June 27, 2022.