St. Jude ICD Class Action Settlement

www.stjudeicdclaim.ca

DERIVATIVE CLASS MEMBER CLAIM FORM

In order to receive a payment from the Settlement Fund, each **Derivative (Family) Class Member** must submit this Claim Form and all required documentation, which **must** be received by the Claims Administrator **no later than 11:59 pm EST on January 10, 2020**.

Late claim submissions will not be accepted or valid.

Derivative Class Members are dependents of Patient Class Members who assert the right to sue the Defendants independently or derivatively by reason of their familial relationship to a Patient Class Member, including pursuant to the *Family Law Act*, RSO 1990 c.F.3 or similar legislation in any other Province or Territory in Canada

SUBMITTING INSTRUCTIONS

There are **four (4) ways** to submit a *Derivative Class Member Claim Form* including all required supporting documentation:

1. ONLINE	Visit the dedicated website at **www.stjudeicdclaim.ca** and submit your Claim **online**
1. MAIL	**Mail** your Claim to: St. Jude ICD Class Action Claims Administrator Nelson P.O. Box 20187 – 322 Rideau Street Ottawa ON K1N 5Y5 Mailed Claims must be postmarked **no later than January 10, 2020.**
2. EMAIL	**Email** your Claim to **info@stjudeicdclaim.ca**
3. FAX	**Fax** your Claim to **1-866-262-0816**

Questions? Call Toll-Free Telephone: **1-833-414-8043**

Important: This Claim Form is for Derivative (Family) Class Members only.

If you are the person who was implanted with one of the affected Defibrillators, you are a Patient Class Member, and you must complete the Patient Class Member Claim Form.

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SECTION A: CLAIMANT NAME AND CURRENT CONTACT INFORMATION

The Claims Administrator will use the information that you provide to process your claim. If this information changes, you **MUST** notify the Claims Administrator in writing.

First Name | Last Name

Street Address

City | Province | Postal Code

Email | Telephone

Please indicate your relationship to the Patient, and provide documented proof of relationship to Patient Class Member

☐ Spouse
☐ Parent
☐ Child (if the child is a minor or disabled, this Claim Form should be completed by the parent or guardian)
☐ Other:_____

Parent or Guardian of Minor Child or Disabled Adult Child (if applicable):

First Name | Last Name

Street Address

City | Province | Postal Code

Email | Telephone

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Patient Class Members are (i) all persons who were Canadian residents on April 23, 2019, or if they died on or before April 23, 2019, they were Canadian residents at the time of death, (ii) who were implanted in Canada with one or more of the affected Defibrillators, and (iii) who did not opt out of this class action.

SECTION B: REQUIRED PATIENT INFORMATION

Patient First Name

Patient Last Name

Make of Patient Defibrillator

Model of Patient Defibrillator

Serial Number of Patient Defibrillator

Patient Implant Date (Month Day, Year)

Patient Implant Location

Patient Date of Birth (Month Day, Year)

Patient Date of Death (Month Day, Year)

If applicable, Date and Location of when/where the Patient Defibrillator was replaced or removed

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Indicate which benefit(s) you are claiming by checking the appropriate box(es) in Section C and/or D.

SECTION C: DEATH BENEFIT FOR DERIVATIVE CLAIMANTS

Derivative Class Members are all persons who were dependents of a deceased Patient Class Member, as that term is defined in the Family Law Act, RSO 1990 c. F.3

Example

- the spouse of the deceased Patient Class Member,
- a parent of the deceased Patient Class Member,
- a child of the deceased Patient Class Member, or
- a brother or sister of the deceased Patient Class Member

In order to claim this benefit, the death of the Patient Class Member **must** have been caused or contributed to by premature battery depletion where the battery depletion occurred earlier than expected based on the Defibrillator's usage, and there was no indication that the depletion was related to a cause other than a short circuit that may have been due to the formation of lithium clusters.

Check the box below if you are claiming a Death Benefit Payment.

√ if claiming	Payment
☐	• **$60,000.00 CAD** to spouse
☐	• **$45,000.00 CAD** to each minor child (a separate Claim Form is required for each claimant)
☐	• **$20,000.00 CAD** to each adult child or parent (a separate Claim Form is required for each claimant)

SECTION D: OUT OF POCKET EXPENSES

Important: If you are claiming Out of Pocket Expenses, the total **must exceed $100.00**, up to a maximum of $500.00 CAD, and must be related to actions taken in response to the receipt of the St. Jude advisory released on October 10, 2016. Expenses may include, but are not limited to, additional clinic attendances, hospital visits or surgery.

Check the box below if you are claiming Out of Pocket Expenses, and indicate the total amount that you are claiming.

√ if claiming	Benefit	Required Documentation	Total Amount Claiming
☐	**Out of Pocket Expenses**	Receipts	$_____**CAD** (maximum $500.00 CAD)

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SECTION E: CLAIMANT NARRATIVE IN SUPPORT OF THE CLAIM

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SECTION F: SOLEMN DECLARATION

I solemnly declare that I have read and understand the contents of this Claim Form. I declare under penalty of perjury that the statements I have made in this Claim Form are true, correct and complete to the best of my knowledge, information and belief.

Executed on_____, in_____, _____
Date (Month Day, Year) City Province

_____ _____
Claimant Printed Name Claimant Signature