Claims Administrator
P.O. Box 4454, Toronto Station A
25 The Esplanade
Toronto, ON M5W 4B1

C5Q

Crisante, et al. v.
DePuy Orthopaedics, Inc., et al.

ONTARIO SUPERIOR
COURT OF JUSTICE

Civil Action No. CV-10-415777-00CP

Must Be Postmarked
No Later Than
March 14, 2022

CLAIM FORM

Canadian National DePuy ASR Hip Implant Class Action

This form and all supporting documents must be completed and submitted to the Claims Administrator by e-mail or mail postmarked **no later than March 14, 2022 at the following address:**

info@DePuyASRClassAction.ca
P.O. Box 4454, Toronto Station A
25 The Esplanade, Toronto, ON M5W 4B1

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

I am making a claim:

- ○ as a Claimant who was implanted with one or more ASR Implants.
- ○ as the Representative of a Claimant (i.e., the Claimant's lawyer, or a person who is the legal representative of a Claimant who is deceased or under a legal disability).

Section A: Claimant Information

First Name ____ M.I. ____ Last Name ____

MM / DD / YYYY
Date of Birth ____ Gender ____

Primary Address ____

City ____ Province ____ Postal Code ____

Daytime Phone Number ___ — ___ — ____ Cellular Phone Number ___ — ___ — ____

Email Address ____

Current Provincial Health Insurance Number ____

FOR CLAIMS PROCESSING ONLY	OB	CB	○ DOC ○ LC ○ REV	○ RED ○ A ○ B

Section B: Prior Residences

Which province did the Claimant reside in at the following points in time?

Question	Province
1. When the Claimant was first implanted with an ASR Implant ("Initial ASR Surgery")?	
2. If applicable, when the Claimant underwent surgery to replace the cup or any component of an ASR Implant ("Revision Surgery")?	
3. On July 30, 2014 (the date the Opt-out period in the Canadian National DePuy Class Action expired)?	

Section C: Legal or Personal Representative

Are you completing this form as someone with the legal capacity to act on behalf of the Claimant (i.e., the Claimant's lawyer, 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.

Are you the Claimant's lawyer?

○ Yes ○ No

First Name M.I. Last Name

Law Firm Name (if applicable)

Primary Address

City Province Postal Code

Email Address

Daytime Phone Number — — Cellular Phone Number — —

Relationship to Claimant:

If you are not the Claimant's lawyer, 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

Where a Claimant is represented by a lawyer, all payments in relation to an Approved Claim, including any Family Law Claim as referenced in Section K, will be paid to the Claimant's lawyer, in trust.

Section D: ASR Implant Information

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

MM / DD / YYYY

Date of Initial ASR Surgery (Right)

Name of Hospital

Surgeon

MM / DD / YYYY

Date of Initial ASR Surgery (Left)

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.

In which hip(s) did you receive an ASR Implant during a Revision Surgery? ○ Right ○ Left ○ Both (Bilateral)

MM / DD / YYYY

Date of Surgery

Name of Hospital

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, or been recommended by their physician to undergo, 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, or were recommended by their physician to undergo, Revision Surgery:

○ Right ○ Left ○ Both (Bilateral)

MM / DD / YYYY

Revision Surgery Date (Right)

Name of Hospital

Surgeon

MM / DD / YYYY

Revision Surgery Date (Left)

Name of Hospital

Surgeon

If the Claimant's Revision Surgery has not yet been scheduled, please provide the date of the physician's recommendation to undergo Revision Surgery, as reflected in the contemporaneous medical records.

MM / DD / YYYY

Revision Surgery Date Reccomendation

Operative report(s) and hospitalization summary sheets for the Claimant's Revision Surgery/Revision Surgeries must be submitted with this Claim Form. If the Claimant has not yet had Revision Surgery, please submit contemporaneous medical records containing the recommendation by the Claimant's physician to undergo Revision Surgery, along with any available records confirming the date and location of the Claimant's upcoming Revision Surgery.

Section F: Revision Medically Precluded

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. If contemporaneous records are not available, please provide a signed letter from the Claimant's physician confirming the above.

Section G: Extraordinary Medical Complication - Re-Revision Surgeries

Has the Claimant undergone an additional surgery to replace the artificial implant inserted during Revision Surgery (“Re-Revision”)?

○ 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?

Date(s)

Name of Hospital(s)

Surgeon(s)

Which hip(s) underwent Re-Revision Surgery? ○ Right ○ Left ○ Both (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 - Other

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 in the chart below,

If not, please skip to Section I below.

Extraordinary Medical Complication	Date Experienced
A foot drop associated with Revision Surgery and/or Re-Revision Surgery	MM / DD / YYYY
A luxation/dislocation requiring a closed reduction medical procedure after Revision Surgery or Re-Revision Surgery	MM / DD / YYYY
A stroke associated with and taking place within one (1) week of Revision Surgery or Re-Revision Surgery	MM / DD / YYYY
A heart attack associated with and taking place within one (1) week of Revision Surgery or Re-Revision Surgery	MM / DD / YYYY
A deep vein thrombosis or pulmonary embolism associated with and taking place within one (1) month of Revision Surgery and/or Re-Revision Surgery	MM / DD / YYYY
A femoral nerve palsy associated with Revision Surgery and/or Re-Revision Surgery which has not resolved within three (3) months thereof	MM / DD / YYYY
An infection in the revised hip within 30 days of Revision Surgery and/or Re-Revision Surgery	MM / DD / YYYY
Death	MM / DD / YYYY

If you experienced any of the above Extraordinary Medical Complications, you must submit medical records associated with the Extraordinary Medical Complication(s).

Section I: Income Loss

Is the Claimant claiming income loss relating to the Revision Surgery?

○ Yes ○ No

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

Basic Income Loss

Was the Claimant employed (including self-employed) at the time of their Revision Surgery?

○ Yes ○ No

Was the Claimant 64 years of age or younger at the time of their Revision Surgery?

○ Yes ○ No

If you checked "No" to either of the above questions, but wish to claim loss of income, OR if you wish to claim income loss in excess of $5,000 gross, please fill out the "Enhanced Income Loss" section below and attach supporting documentation. Otherwise, please skip to Section J.

Enhanced Income Loss

What period of time is the Claimant claiming loss of income for? Please provide dates:

Date(s)

What was the Claimant's annual gross income:

The year before the Claimant's Revision Surgery?	$
Two years before the Claimant's Revision Surgery?	$
Three years before the Claimant's Revision Surgery?	$
Four years before the Claimant's Revision Surgery?	$
The year of the Claimant's Revision Surgery?	$
The year after the Claimant's Revision Surgery?	$
Two years after the Claimant's Revision Surgery?	$

What is the total Enhanced Income Loss you are claiming as a result of the Revision Surgery?

$

If you are claiming for Enhanced Income Loss, you must submit documentation, including tax records confirming income on each of the years listed above (including the years after the Revision Surgery, if available), to support your claim.

If you are only claiming for Basic Income Loss, were 64 years of age or younger and employed at the time of the Revision Surgery, you do not need to provide supporting documents.

Section J: Out of Pocket Expenses

Is the Claimant claiming out-of-pocket expenses relating to the Revision Surgery?

◯ Yes ◯ No

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

If you checked “Yes”, please fill in the following information as supported by receipts:

Date Incurred mm/dd/yyyy	Description	Amount
MM / DD / YYYY		$.
MM / DD / YYYY		$.
MM / DD / YYYY		$.
MM / DD / YYYY		$.
MM / DD / YYYY		$.
MM / DD / YYYY		$.
MM / DD / YYYY		$.
MM / DD / YYYY		$.
MM / DD / YYYY		$.

What is the total amount of out of pocket expenses you are claiming?

$.

If you are claiming for Out-of-Pocket Expenses, you must submit receipts to support your claim.

Section K: Family Law Claims

Will a family member [a spouse, child, grandchild, parent, grandparent, brother, or sister] of the Claimant be seeking compensation under this settlement for expenses incurred in caring for the Claimant, and/or for loss of guidance, care, and/or companionship due to the Claimant's injuries?

○ Yes ○ No

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

If you checked "Yes", please provide the contact information of the family member who the Claimant designates as the Family Claimant under this Settlement:

First Name | M.I. | Last Name

MM / DD / YYYY
Date of Birth | Gender

Primary Address

City | Province | Postal Code

Email Address

— — Daytime Phone Number | — — Cellular Phone Number

Relationship to the Claimant

IMPORTANT: In order for the family law claim to be processed, the family member listed above must complete the "Family Claim Form" and submit it to the Claims Administrator.

Section L: Mailing Address for Compensation

If you are approved to receive compensation under this settlement, you will receive a cheque in the mail after the end of the Claims Deadline.

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

○ Yes ○ No

If "No", your cheque 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:

Primary Address

City | Province | Postal Code

Section M: Claimant 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.

The Claimant has not made a successful claim for compensation in relation to the ASR Implants under any other class action or lawsuit.

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 and other 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.

If applicable, the Claimant designates the individual listed at Section K above as the Family Claimant in this action, and confirms that they were a family member [a spouse, child, grandchild, parent, grandparent, brother, or sister] in a close relationship with the Claimant at the time of the Claimant's Revision Surgery, and incurred expenses and/or the relationship was negatively impacted as a result of the Revision Surgery (i.e., experienced loss of guidance, care, and/or companionship).

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 Dated (mm/dd/yyyy)

____

Print Name

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

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