

Section B: Claimant Information

I have confirmed with the Claimant that they are making a claim for compensation under this Settlement relating to their injuries from the ASR Implant and that they will/have designate(d) me as their Family Claimant in Section K of their Claim Form.

Yes No

If you checked “No”, please do the above before submitting this Family Claimant Form.

If the Claimant does not submit their own claim under this settlement, the Family Claimant is not eligible for any compensation.

Please provide the name and contact information of the Claimant who was implanted with the ASR Implant for whom you are the Family Claimant below:

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

The Claimant listed above is my:

- Spouse
- Parent
- Sibling
- Grandparent
- Child
- Grandchild

Section C: Family Claimant Declaration

I solemnly declare that:

I wish to make a claim for compensation in this class action.

I am a family member [spouse, child, grandchild, parent, grandparent, brother, or sister] of the Claimant who has/had a close relationship with the Claimant at the time of their Revision Surgery, and I incurred expenses in caring for the Claimant, and/or experienced a negative impact on my relationship with the Claimant (i.e., loss of guidance, care, and/or companionship) as a result of the Claimant’s Revision 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 Family Claimant: _____

Dated (mm/dd/yyyy): _____

Printed Name of Family Claimant: _____

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

