CLAIM FORM

Stryker Rejuvenate Modular Hip Implant Class Action

For Claimants Revised as of February 6, 2020 and for Medically Precluded Claimants: This form must be completed and returned to the Claims Administrator by October 16, 2020.

For Claimants Revised *after* February 6, 2020 but *before* September 29, 2022: This form must be completed and returned to the Claims Administrator no later than ninety (90) days after your Qualified Revision Surgery or by September 29, 2022, whichever date is earlier.

I am making a claim either myself or through my lawyer:

☐ as a Claimant who was implanted with the Stryker Rejuvenate Modular Hip Implant (the "Rejuvenate Modular").

☐ as the Representative (a person who is the legal representative of a Claimant who is deceased or under a legal disability) of a Claimant.

If you have any questions or need assistance completing this form, you may contact the Claims Administrator by email at strykerclassaction@epiqglobal.ca. You may also contact Class Counsel.

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 Rejuvenate Modular?

☐ Yes ☐ No

If you checked "Yes," please list the Claimant's other province(s) of residence, the date(s) of residence, 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," please 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 the 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 represented by a lawyer)

Lawyer Last Name Lawyer First Name

Name of Law Firm

Address

Phone Number Email

Section D: Rejuvenate Modular Implant Surgery Information

This section is for a Claimant who was implanted with a Rejuvenate Modular and is making a claim as *either* a Qualified Revision Surgery Claimant (i.e. if your Rejuvenate Modular has been revised in accordance with the Settlement Agreement) *or* a Medically Precluded Claimant. Please complete the information in this Section as applicable.

Claim Type: ☐ Qualified Revision Surgery ☐ Medically Precluded

Location of the Implant: ☐ Right Hip Only ☐ Left Hip Only ☐ Both Left Hip and Right Hip

Right Hip

Implant Date (Right)

(mm/dd/yyyy)

Name of Hospital

Surgeon

Left Hip

Implant Date (Left)

(mm/dd/yyyy)

Name of Hospital

Surgeon

Note: If you checked "Qualified Revision Surgery", complete Sections E – G as applicable. If you checked "Medically Precluded", please skip to Section J.

Required Submissions

In order to enroll in the Settlement Program, you must submit the following documents with your Claim Form:

☐ Manufacturer/product stickers for the Rejuvenate Modular for the device implanted into the Claimant. Only in the event product stickers are not available, please submit the electronic implant log from your Index Surgery.

☐ A copy of the implantation surgery operative report and discharge summary related to the hip(s) at issue.

Section E: Revision Information (if applicable)

If the Claimant underwent a Revision Surgery to remove a Rejuvenate Modular, please select one of the following choices that apply to your claim and complete the following information.

Has the Claimant undergone a Revision Surgery(ies) to remove the Rejuvenate Modular?

☐ Yes ☐ No

If you checked "No," please skip to Section J below. If you checked "Yes," please complete this Section E.

Location of Revision: ☐ Right Hip Only ☐ Left Hip Only ☐ Both Left Hip and Right Hip

Right Hip

Revision Date (Right)

(mm/dd/yyyy)

Name of Hospital

Surgeon (*if different from implanting surgeon identified in Section D*)

Left Hip

Revision Date (Left)

(mm/dd/yyyy)

Name of Hospital:

Surgeon (*if different from implanting surgeon identified in Section D*)

If you have been revised *after* September 25, 2018, please check below the reason for your Revision Surgery (check all that apply):

☐ Elevated cobalt level.

☐ Abnormal diagnostic scan of surrounding tissue related to the reasons underlying the Voluntary Recall.

☐ Intra-operative or pathologic confirmation of adverse local tissue reaction ("ALTR"), aseptic lymphocyte dominated vasculitis-associated lesion ("ALVAL"), or tissue damage related to the reasons underlying the Voluntary Recall.

Required Submissions

In order to enroll in the Settlement Program and submit a claim for a Qualified Revision Surgery, you must submit the following documents with your Claim Form:

☐ A copy of the Revision Surgery operative report and discharge summary related to the hip(s) at issue.

☐ Manufacturer/product stickers identifying the devices and hardware implanted during the Revision Surgery(ies). Only in the event product stickers are not available, please submit the electronic implant log from your Revision Surgery(ies).

☐ **For Claimants Revised *after* September 25, 2018:** A copy of Contemporaneous Medical Records that support the reason for your revision surgery was either: (i) an elevated cobalt level; (ii) an abnormal diagnostic scan of surrounding tissue related to the reasons underlying the Voluntary Recall; and/or (iii) intra-operative or pathologic confirmation of adverse local tissue reaction ("ALTR"), aseptic lymphocyte dominated vasculitis-associated lesion ("ALVAL"), or tissue damage related to the reasons underlying the Voluntary Recall.

Section F: Enhancements

This section is for a Claimant who has undergone a Qualified Revision Surgery(ies) and qualifies for one of the below-listed Enhancements. All Enhancement claims are subject to an aggregate cap of $65,000 (CAD) for qualifying Unilateral Revision Claimants and $80,000 (CAD) for qualifying Bilateral Revision Claimants, including Income Loss in Section I below. **Note that Medically Precluded Claimants are not entitled to Enhancements under the Settlement Program.**

Check each category for which the Claimant believes s/he is entitled to compensation and for which s/he is submitting an application. If the Claimant is seeking an Income Loss Enhancement, s/he must complete Section G.

Enhancement Category

Category I: Dislocation

Dislocation – Closed Reduction ☐

Dislocation – Open Reduction ☐

Dislocation – Open Reduction with Conversion to a Constrained Component ☐

Category II: Blood Clot

Blood Clot ☐

Category III: Infection

Infection-Related Open Surgical Procedure ☐

Infection-Related Non-Surgical Treatment ☐

Category IV: Events Associated with Qualified Revision Surgery or Re-Revision Surgery

Osteotomy ☐

Intraoperative Femur Fracture with Osteotomy ☐

Intraoperative Femur Fracture without Osteotomy ☐

Surgical Repair/Reattachment of a Damaged Abductor Muscle Complex ☐

Category V: Re-Revision Surgery

Re-Revision Surgery – First Re-Revision ☐

Re-Revision Surgery – Second Re-Revision ☐

Category VI: Additional Surgery

Additional Surgery ☐

Category VII: Foot Drop

Foot Drop ☐

Category VIII: Myocardial Infarction

Myocardial Infarction ☐

Category IX: Stroke

Stroke ☐

Category X: Related Death

Related Death ☐

Required Submissions:

In order to enroll in the Settlement Program and submit a claim for an Enhancement, you must submit the following documents with your Claim Form:

☐ Manufacturer/product stickers identifying the devices and hardware implanted during each surgery for which you are claiming an Enhancement.

☐ Operative reports, if applicable, and other records or notes for each surgery for which you are claiming eligibility that show you are entitled to your claimed Enhancement(s). By way of example, such other records or notes might include for each claimed Enhancement:

(a) admission histories, emergency room records (if applicable), pathology reports, radiology or imaging reports, and discharge summaries;

(b) contemporaneous progress notes, lab results, and/or radiology/imaging/diagnostic reports from the treating orthopedic surgeon(s) relating to the hip(s) at issue for the time period from the implantation surgery to each event and/or surgery for which you are claiming an Enhancement;

(c) contemporaneous progress notes, lab results, and/or radiology/imaging/diagnostic reports from any other treating physician (e.g. cardiologist, infections disease specialist, cardiothoracic surgeon, pulmonologist, neurologist) from the time period from the implantation surgery to each event and/or surgery for which you are claiming an Enhancement.

Section G: Income Loss

This section is for a Claimant who is claiming an income loss related to a Qualified Revision Surgery. In order to be eligible for this Enhancement, the Claimant must demonstrate an actual economic loss. As a result, this Enhancement is not available to a Claimant who was not employed and/or retired at the time of his/her Qualified Revision Surgery. The maximum award for Income Loss under the Settlement Agreement is $10,000 (CAD). If the Claimant is claiming an income loss of more than $10,000 (CAD), s/he will be limited to the maximum amount of $10,000 (CAD) (if applicable and if deemed eligible for this Enhancement). In addition, the income loss Enhancement is subject to an aggregate cap of $65,000 (CAD) for qualifying Unilateral Revision Claimants and $80,000 (CAD) for qualifying Bilateral Revision Claimants as set forth in Section F above. **Medically Precluded Claimants are not entitled to an Income Loss Enhancement under the Settlement Program.**

Is the Claimant asserting a claim for Income Loss under the Settlement?

☐ Yes ☐ No

If you checked "No," please skip to Section K. If you checked "Yes," please complete this section.

Please briefly explain the basis for your Income Loss claim:

Required Submissions

In order to enroll in the Settlement Program and submit a claim for Lost Income, you must submit the following documents with your Claim Form:

☐ Income Tax Statements, T4s, Notices of Assessment or other statements that evidence the Claimant's income from employment or self-employment from two years preceding the Implant Surgery to present.

☐ Supporting Employment records from two years preceding the Implant Surgery to the present.

Section H: Out-of-Pocket Expenses

This section is for a Claimant who has undergone a Qualified Revision Surgery(ies) and has incurred out-of-pocket expenses associated with that Qualified Revision Surgery(ies). Under the Settlement Agreement, such Claimant may receive a **single award of up to** $2,500 (CAD) for out-of-pocket expenses related to the Qualified Revision Surgery(ies), regardless of whether the Claimant is a qualifying Bilateral Revision Surgery Claimant. All claims under this Section H must be supported by documentary proof. A Claimant who is claiming more than $2,500 (CAD) in out-of-pocket expenses will be limited to a maximum of $2,500 (CAD) (if applicable and if deemed eligible for this Enhancement). **Medically Precluded Claimants are not entitled to claim out-of-pocket expenses under the Settlement Program.**

Did the Claimant incur any out-of-pocket expenses in connection with a Revision Surgery, post-revision complications, or medical treatment?

☐ Yes ☐ No

If you checked "No," skip to Section I. If you checked "Yes," please answer the following:

Are these claimed out-of-pocket expenses $2,500 (CAD) or less?

☐ Yes ☐ No

If you checked "Yes" above, you are entitled to recover no more than $2,500 (CAD) in out-of-pocket expenses. Do you have receipts to substantiate the expenses you incurred?

☐ Yes ☐ No

Required Submissions

If "Yes," please attach your receipts to this form. If "No," please state the approximate total of the expenses you incurred: $_____.

For all Claimants who are making a claim for out-of-pocket expenses, please provide a description of expenses incurred below.

Expenses: Amount:

Section I: Claimant's Principal Caregiver Information (if applicable)

This section is for a Principal Caregiver who provided care for an enrolled Claimant who underwent a Qualified Revision Surgery. Only a family member may qualify as a Principal Caregiver. Under the Settlement, a Principal Caregiver may be entitled to receive a **single award of up to** $5,000 (CAD), regardless of the number of caregivers or whether the Claimant is a qualifying Bilateral Revision Surgery Claimant. **Note that family members of Medically Precluded Claimants are not entitled to claim a Principal Caregiver award.**

Did a family member provide the Claimant with care to assist in the Claimant's recovery after his/her Qualified Revision Surgery(ies) to remove the Rejuvenate Modular?

☐ Yes ☐ No

If you checked "No," please skip to Section K. If you checked "Yes," list the family member's name and his/her relationship to the Claimant:

Name of Family Member Relationship to Claimant

Please Note: If a family member is making a claim as a Principal Caregiver, that family member must also complete the attached Principal Caregiver Declaration under Section L below and include it with this form.

Section J: Medically Precluded Claimant (if applicable)

This section is **only** for a Claimant who qualifies as a Medically Precluded Claimant. A Medically Precluded Claimant is a Claimant for whom, as of May 2, 2019, a Revision Surgery of his/her Rejuvenate Modular has been recommended, but s/he is unable to undergo a Revision Surgery due to the existence of a documented medical condition. The need, and reason, for the Revision Surgery, and the determination of an inability to undergo the Revision Surgery due to the existence of a documented medical condition, must be established by medical records made at the time of the respective determinations. Please note that age is not a medical condition. **If the Claimant is not a Medically Precluded Claimant, please skip to Section K below. Please note that if the Claimant is unrevised but is *not* a Medically Precluded Claimant, s/he is not eligible for the Settlement Program.**

Has the Claimant's doctor recommended Revision Surgery prior to May 2, 2019, but also advised the Claimant that he or she is unable to undergo a Revision Surgery due to the existence of a documented medical condition?

☐ Yes ☐ No

Please identify the name and address of the doctor who advised the Claimant, the date of discussion, and the medical condition(s) that prevents the Claimant from having a Revision Surgery.

Doctor:

Address:

Approximate Date(s) of Discussion (MM/DD/YYYY):

Medical condition(s):

Required Submissions

In order to enroll in the Settlement Program and submit a claim as a Medically Precluded Claimant, you must submit the following documents with your Claim Form in addition to the applicable Required Submissions identified in Section D:

☐ Copies of **specific** Contemporaneous Medical Records created prior to May 2, 2019 that support the Claimant's claim that a Revision Surgery is recommended by his/her treating orthopaedic surgeon due.

☐ Copies of **specific** Contemporaneous Medical Records created prior to the May 2, 2019 by the treating physician or consulting medical specialist that support the Claimant's claim that s/he is too infirm to undergo a Revision Surgery.

Section K: Declaration

I solemnly declare that:

The Claimant was implanted with a Rejuvenate Modular.

The Claimant wishes to make a claim for compensation in this Settlement.

Attached are copies of the Claimant's implant and revision (if applicable) operative reports and documentation identifying the catalogue and lot numbers of the Claimant's Rejuvenate Modular.

I have also attached copies of all other Contemporaneous Medical Records and other documents upon which the Claimant relies in support of my claim.

I declare the statements in this form 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 form and all supporting documents must be submitted to the Claims Administrator on or before the applicable Claims Period Deadline.

Section L Principal Caregiver Declaration (if applicable)

Please Note: This form must be completed if a family member is making a claim as a Principal Caregiver.

First Name | Middle | Last Name

Address

City | Province/Territory | Postal Code

Daytime Phone Number | Cellular Phone Number

Email

Name of Claimant

Relationship to Claimant

Did you provide primary care to a Claimant?

☐ Yes ☐ No

If you checked "Yes," please state the nature of the care you provided. Please provide approximate dates and sufficient detail to allow for an understanding of the care provided and the impact upon you.

Did you incur personal expenses in order to provide care to the Claimant?

☐ Yes ☐ No

If you checked “Yes,” please attach your receipts for expenses to this form. If you checked “No,” please state the approximate total of the expenses you incurred: $_____. Please provide a description of expenses incurred below.

Expenses	Amount
	_____
	_____
	_____
	_____

I declare the statements in this form to be true, and knowing that it is of the same legal force and effect as if it were made under oath.

_____ _____

Signature of Principal Caregiver Date