ALLERJECT NATIONAL CLASS ACTION SETTLEMENT
PERSONAL INJURY CLAIM FORM

UNLESS NOTED OTHERWISE, YOU MUST ANSWER ALL OF THE QUESTIONS ON THIS CLAIM FORM, INCLUDE THE REQUESTED DOCUMENTATION, AND, IF NECESSARY, ATTACH ADDITIONAL SHEETS.
(Please type or use blue or black pen and write legibly)

CLAIMS DEADLINE: SEPTEMBER 12, 2019

To be eligible for an indemnity if you are a qualifying Settlement Class Member, you must file a Claim Form before September 12, 2019.

OVERVIEW OF THE CLAIMS PROCESS:
To be eligible for compensation, it is necessary that you first establish that you purchased, used, ingested or acquired an Allerject epinephrine auto-injector in either 0.15mg/0.15mL and 0.3mg/0.3mL strength (referred to as an ***Allerject Device***) in Canada or you are the spouse, child, grandchild, parent, grandparent, brother or sister of the person who purchased, used, ingested or acquired an Allerject Device and by reason of that relationship with that person at law you are entitled to assert a claim.

If you meet this requirement, and you allege that you (or the person you are claiming on behalf of) suffered personal injury in one of the following two circumstances, you may be entitled to recover:

A. Circumstance A - Level A Claim — You (or the person you are claiming on behalf of) used an unexpired Allerject Device due to an allergic reaction, and the Allerject Device did not provide the expected pharmacological response and you (or the person you are claiming on behalf of) were required to seek emergency medical treatment without being hospitalized. If established you will be entitled to a payment of $2,000.

B. Circumstance B - Level B Claim - You (or the person you are claiming on behalf of) used an unexpired Allerject Device due to an allergic reaction, and the Allerject Device did not provide the expected pharmacological response and you (or the person you are claiming on behalf of) were required to seek emergency medical treatment and was hospitalized as a result of said allergic reaction. If established you will be entitled to a payment of $4,000.

If you fall within the circumstances described in either Circumstance A or B, you may be entitled to compensatory damages if you file this Claim Form by the Claims Deadline of **September 10, 2019.**

Each Claim Form must be supported by proof or documentation as outlined herein and must comply with all other conditions and requirements specified herein, and will be considered and validated by the Claims Administrator. Note that the medical and pharmacy records set out below are necessary in order for the Claims Administrator to properly evaluate whether you satisfy the eligibility requirements as outlined in the Settlement Agreement and to perform a valuation of the claim.

Accordingly, the Claims Administrator will closely review the completeness of each Claim Form and supporting documentation to ensure that a complete set of the required pharmacy and medical records has been produced and that there is no evidence that any records have been withheld or in any way altered.

“Medical Records” means the entire record maintained by an individual healthcare provider or facility relating to the medical and/or history, care, diagnosis and treatment of a claimant including new patient intake forms completed by or on behalf of the claimant, doctors’ notes, nurses’ notes, physicians’ orders, consultation reports, laboratory test results, reports of any diagnostic procedures, admission summaries, discharge summaries, consent forms, prescription or medication administration records, and all communications between a healthcare provider and a claimant (or his/her legal representative/guardian) or between two or more healthcare providers relating to a claimant.

“Pharmacy Records” means all documents that relate to the preparation, dispensing and provision of medicine, medical devices, or other treatment modalities by a pharmacy or any other person that dispenses prescription medication, or from a provincial healthcare organization that has a central registry of all prescriptions dispensed to an individual.

FOR MORE INFORMATION OR ASSISTANCE WITH THIS FORM www.allerjectrecallsettlement.com		
	Merchant Law Group LLP (Class Counsel)	
Trilogy Class Action Services Allerject Recall Class Action Settlement 117 Queen Street, PO Box 1000 Niagara-on-the-Lake ON L0S 1J0 Tel: 1-866-329-7153 Fax: 1-416-342-1761 inquiry@trilogyclassactions.ca	**For Quebec Residents** 200-10 Notre-Dame Est Montreal, QC H2Y 1B7 Erik Lowe Tel: (514) 248-7777 Fax: (514) 842-6687 allerject@merchantlaw.com	**For Non-Quebec Residents** 2401 Saskatchewan Drive Regina, SK S4P 4H8 E.F. Anthony Merchant, Q.C. Tel: (306) 359-7777 Fax: (306) 522-3299 allerject@merchantlaw.com

Name and Contact Details of the Party Who is Claiming:

First Name: **Middle Name:** **Last Name:**

Street Address: **Country:**

City or Town: **Province:** **Postal Code:**

Home Number: **Email Address:**
Area Code Number

Language Preference: ☑ English ☐ French

If you are Claiming on behalf of a Person, name of the Person you are claiming on behalf of or the name of the Insured Person:

First Name: **Middle Name:** **Last Name:**

Street Address: **Country:**

City or Town: **Province:** **Postal Code:**

Home Number: **Email Address:**
Area Code Number

Language Preference: ☑ English ☐ French **Relationship to the Person:**

Please attach to this Claim Form a document(s) showing your authority to act on behalf of the claimant (e.g. a Power of Attorney, Letters of Administration, a Will, a Death Certificate).

LEGAL COUNSEL IDENTIFICATION (IF APPLICABLE)

This Section is to be completed only if a lawyer is representing the claimant. Please note that if you complete this Part, all correspondence will be sent to your lawyer.

Law Firm Name:

Lawyer's Name:

Street Address:

City or Town:

Province:

Postal Code:

Phone Number:
Area Code Number

Fax Number:
Area Code Number

Email Address:

HEALTHCARE PROVIDER INFORMATION:

Primary physician involved in the care of the individual that gives rise to the Claim:

Name:

Street Address:

City or Town:

Province:

Postal Code:

Phone Number:
Area Code Number

Fax Number:
Area Code Number

Email Address:

PRIMARY PHYSICIAN INVOLVED IN PRESCRIBING THE ALLERJECT DEVICE:

Name:

Street Address:

City or Town: **Province:** **Postal Code:**

Phone Number:
Area Code Number

Fax Number:
Area Code Number

Email Address:

PHARMACIST WHO DISPENSED THE ALLERJECT DEVICE:

Name:

Street Address:

City or Town: **Province:** **Postal Code:**

Phone Number:
Area Code Number

Fax Number:
Area Code Number

Email Address:

FACTS CONCERNING USE OF ALLERJECT DEVICE THAT GIVES RISE TO CLAIM:

Date Allerject Device Acquired:

Lot Number (if available): **Expiry Date (if available):**

Please provide a copy of the Pharmacy Records in relation to the dispensation of the Allerject Device

ALLEGED CIRCUMSTANCES:

Describe the alleged circumstances giving rise to the use of the Allerject Device:

COURSE OF TREATMENT

Describe the additional emergency medical treatment and/or hospitalization following deployment of the Allerject Device, including the name(s) and address(es) of any healthcare provider or hospital who has treated, particulars of any procedure(s) undertaken or medications prescribed, and provide supporting documentation as required below:

Please provide a copy of the Medical Records of any healthcare professional or hospital who has treated the individual as a result of their use of the Allerject Device and which supports the information provided above from the date of use to the date that the medical condition fully resolved.

☐ I solemnly declare that all of the information provided in this Claim Form which Claim Form has been approved for the purposes of the Settlement Proceedings is true and correct and that all records produced are true, complete, and correct copies of the records provided to me by the healthcare provider(s), pharmacy(ies), provincial healthcare organization(s) and/or insurance companies.

☐ I acknowledge that knowingly submitting a false claim could constitute civil or criminal fraud and contrary to the Order of the Court in these proceedings.

Date:

Signature:

Print Name:

Witnessed By:

Date:

Signature:

Print Name: