

Maxim's Bakery Salmonella Class Action

CLAIM FORM

A separate claim form must be filled out for each claimant. If more than one person in your family was infected, please complete a separate claim form for each family member.

Additional claim forms are included for your convenience.

Please mail or deliver this form by no later than _____, 2002 to:

Sovereign General Insurance Company, Attn: Linda Westerlund
1400 – 1095 West Pender Street
Vancouver, B.C. V6E 2M6
Telephone: (604) 602-8300 Toll Free: 1-800-663-1924
Claims Toll Free: 1-800-665-3993 Fax: (604) 681-4303
Claims Fax: (602) 602-1057

Note: If your claim form is not mailed or delivered on or before the date printed above, YOU MAY LOSE YOUR RIGHT TO MAKE A CLAIM.

Representative Information

Complete this section only if you are acting as the representative of a person under disability, if you are a lawyer representing the claimant, if you are the parent of a claimant under 19 years of age or if you are acting in some other representative capacity.

	Relationship with applicant
Last Name: <u>LYONS</u>	Parent of Minor
	Guardian
	Representative of Estate
	Lawyer
	Other: _____
First Name & Initial: <u>MARK L.</u>	
Name of Law Firm (if applicable): <u>KLEIN LYONS</u>	
Address: <u>#1100 – 1333 West Broadway</u>	
City: <u>Vancouver</u>	Province: <u>B.C.</u> Postal Code: <u>V6H 4C1</u>
Phone: <u>604 – 874-7171</u>	Fax: <u>604 – 874-7180</u>
E-mail: <u>cross@kleinlyons.com</u>	

Claimant Information

This information must be provided for each claimant. Please answer all of the questions. Add extra pages if you need more space.

Last Name _____

First Name & Initial _____

Address _____

City _____ Province _____ Postal Code _____

Birth Date: Year _____ Month _____ Day _____

Home Phone _____ - _____ Work Phone _____ - _____

You can be reached:

by telephone at home

by telephone at work

by letter

other _____

Was the Claimant a resident of British Columbia on April 11, 2002? Yes No

Did the Claimant consume a Maxim's Bakery Product in August or September 2000 and suffer personal injuries as a result? Yes No

Where and when was the Maxim's Bakery Product purchased? (if known)

Date: _____

Place: _____

Where and when was the Maxim's Bakery Product consumed? (if known)

Date: _____

Place: _____

Which Maxim's Bakery Product was consumed? (if known)

Did the Claimant test positive for Salmonella *enteritidis* infection in August or September 2000? Yes No Don't Know

If the answer to the above question is "YES," please state the date on which the Claimant tested and the place where the sample was tested?

Date: _____

Place: (eg. name of hospital/clinic etc.) _____

Please complete the following box if the Claimant was hospitalized for more than 30 days, or has continuing symptoms.

Please describe the Claimant's symptoms.

Symptom	Duration

Was the Claimant admitted to hospital? Yes No

(Note: Attendance at an emergency department or health clinic is not admission to hospital.)

If the Claimant was admitted to hospital,

Name of hospital _____

Number of days in hospital _____

Have you attached hospital records showing dates, times, place and reason for admission to hospital? Yes No

Are you applying for reimbursement of out-of-pocket expenses (including time off work)? Yes No

List any medical or other out-of-pocket expenses that are not covered by MSP, any other insurance plan or any other relief plan and attach available receipts.

Expense	Amount

If you were unable to work because of your Salmonella infection or because of the infection of a family member, how many days were you off work? _____

What was your loss of income? \$ _____ What is your occupation? _____

Where did you work? _____

Identify your supervisor's name and telephone number. _____

Are you self-employed? Yes No

