SCHEDULE A - CLAIMANT DECLARATION

Zimmer Durom Cup Hip Implant Class Action

This form must be completed and returned to the Claims Administrator by email, mail, fax or in person no later than Tuesday, September 5, 2017

I am making a claim either myself or through counsel:

☐ as a Claimant who was implanted with the Zimmer Durom Cup.

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

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 Durom Cup?

☐ Yes ☐ No

If you checked "Yes," please list the Claimant's other province(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," 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 applicable)

Lawyer Last Name | Lawyer First Name

Name of Law Firm

Address

Phone Number | Email

Section D: Durom Cup Implant Information

Location of the Durom Implant: ☐ Right ☐ Left ☐ Bilateral

Implant Date (Right) _____
(mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

Implant Date (Left) _____
(mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

Identification stickers and operative report(s) for your Durom Cup(s) must be submitted with this Claimant Declaration.

Section E: Revision Information

Has the Claimant undergone a revision surgery or surgeries to remove the Durom Cup(s)?

☐ Yes ☐ No

If you checked "No," please skip to Section F below.

Location of Revision: ☐ Right ☐ Left ☐ Bilateral

Implant Revision Date (Right) _____
(mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

Implant Revision Date (Left) _____
(mm/dd/yyyy)

Name of Hospital _____

Surgeon _____

Section F: Revision Medically Contraindicated

Has the Claimant's doctor recommended a revision, but also advised the Claimant that a revision is medically contraindicated and/or would be life threatening?

☐ Yes ☐ No

If you checked "Yes," please submit a Physician's Declaration completed and signed by your physician with this form and complete the remainder of Section F. If you checked "No," please skip to Section G.

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 the surgery. Please state whether the Claimant has been advised that the condition(s) will permanently prevent the Claimant from having revision surgery, as opposed to delaying a revision surgery.

_____

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

_____

Doctor

_____

Address

Medical condition(s):_____

_____

_____

_____

Section G: Claimant's Immediate Family Information

Complete this section if the Claimant had a revision surgery or is medically precluded from having revision surgery.

If the Claimant had at least one Revision Surgery to remove a Durom Cup, please answer the following:

Did an immediate adult family member provide the Claimant with care to assist in the Claimant's recovery after his/her revision surgery or surgeries to remove the Durom Cup(s)?

☐ Yes ☐ No

If you checked "Yes," list the family member's name and his/her relationship to the Claimant:

_____

Name of Family Member Relationship to Claimant

Did the Claimant have children under the age of 18 who lived with him/her on the date of his/her revision surgery to implant the Durom Cup?

☐ Yes ☐ No

If you checked "Yes," list the names and dates of birth of up to two children only:

Name	DOB: (mm/dd/yyyy)
Name	DOB: (mm/dd/yyyy)

If the Claimant is medically contraindicated from undergoing a revision surgery, please answer the following:

Did an immediate adult family member provide the Claimant with care to assist in the Claimant's recovery after his/her surgery or surgeries to implant the Durom Cup(s)?

☐ Yes ☐ No

If you checked "Yes," list the family member's name and his/her relationship to the Claimant:

Name of Family Member	Relationship to Claimant

Did the Claimant have children under the age of 18 who lived with him/her on the date of his/her surgery to implant the Durom Cup(s)?

☐ Yes ☐ No

If you checked "Yes," list the names and dates of birth of up to two children only:

Name	DOB: (mm/dd/yyyy)
Name	DOB: (mm/dd/yyyy)

Section H: Post-Revision Complications

Did the Claimant's revision surgery or surgeries cause any of the following? If so, state the date on which the complication occurred.

	Date (mm/dd/yyyy)
Second Revision (Right)	_____
Second Revision (Left)	_____
Third Revision (Right)	_____
Third Revision (Left)	_____
Stroke	_____
Blood Clot	_____
Infection	_____
Permanent nerve damage	_____
Death	_____

If you claimed above that the Claimant experienced a blood clot, infection, and/or permanent nerve damage, you must submit a completed Physician's Declaration with this form. If you claimed above that the Claimant suffered from a second revision, a third revision, death, or a stroke, you must submit hospital records (including revision operative reports) relating to each complication, or a Physician's Declaration documenting each complication, with this form.

Section I: Out-of-Pocket Expenses

Complete this section only if the Claimant had a revision surgery or is medically precluded from undergoing revision surgery.

☐ Check here if the Claimant purchased his or her Durom Cup(s) with his or her own funds (*i.e.*, the cost of the implant was not paid by an insurer). If you checked the box, attach all receipts or other documentation reflecting the amount paid by the Claimant for the Durom Cup(s) to this form.

Did the Claimant (who has been revised or is medically precluded from undergoing a revision) incur any other 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 J. If you checked "Yes," please answer the following:

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

☐ Yes ☐ No

If you checked "No," and you wish to seek reimbursement for the expenses you incurred that are greater than $2,500, you may complete and submit the Extraordinary Expense Pool Claim Form. Please note that you are required to provide receipts substantiating all of your out-of-pocket expenses if you seek reimbursement totaling more than $2,500. If you choose to complete the Extraordinary Expense Pool Claim Form, please attach the receipts substantiating the expenses you seek to recover up to $2,500 to this Claimant Declaration and attach the receipts substantiating any additional expenses you seek to recover to the Extraordinary Expense Pool Claim Form

If you checked "Yes" above, or you seek to recover no more than $2,500 in out-of-pocket expenses, do you have receipts to substantiate the expenses you incurred?

☐ Yes ☐ No

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

Section J: Declaration

I solemnly declare that:

The Claimant was implanted with one or more Durom Cup acetabular component(s) ("Durom Cup").

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

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 Durom Cup.

If I am not submitting the Claimant's Durom Cup peel-and-stick labels as product identification, it is because the hospital at which the Claimant's implant surgery occurred could not provide me with the labels because they are not in the Claimant's hospital medical records.

If I am not submitting a photograph of the Claimant's Durom Cup in lieu of the Claimant's Durom Cup peel-and-stick labels, I cannot submit a photograph because the Claimant's Durom Cup is not within the Claimant's or my possession, custody, or control.

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 Date

Please note: All pages of this Declaration and supporting documents must be submitted to the Claims Administrator on or before the Claims Deadline.