Zyprexa Settlement Agreement

CLAIM FORM PACKAGE

This Claim Form Package contains a:

- Privacy Statement
- Instructions for Claimants
- Summary of the Settlement Agreement
- Claim Form
- Medical Direction Form

PRIVACY STATEMENT

Personal Claimant Information is collected, used, and retained by the Claims Administrator pursuant to the Personal Information Protection and Electronics Documents Act (PIPEDA):

- For the purpose of operating and administering the Zyprexa Settlement Agreement,
- To evaluate and consider the claimant's eligibility status under the Zyprexa Settlement Agreement,
- Is strictly private and confidential and will not be disclosed without the express written consent of the claimant, except as provided in the Zyprexa Settlement Agreement.

INSTRUCTIONS FOR CLAIMANTS:

These instructions summarize the provisions of the Settlement Agreement. In the case of contradiction between these instructions and the Settlement Agreement, the Settlement Agreement shall prevail.

To establish your right to compensation under the terms and conditions of the Zyprexa Settlement Agreement, **you must submit a fully completed, signed, Claim Form with Supporting Documentation to the Claims Administrator postmarked on or before October 28, 2010. Please detach your fully completed Claim Form and return it to the Claims Administrator at the address listed below.**

Settlement Class members who do not submit a fully completed Claim Form, shall forever forfeit their rights to compensation from the Settlement Fund and will be precluded from ever bringing an action against any of the Released Parties unless they have previously Opted Out of the Class.

If you require assistance or advice regarding completion of the Claim Form or have any enquiry related to your claim, you may retain legal counsel at your own expense, or contact the Claims Administrator toll free: **1-877-739-8933**, or by email: zyprexa@crawco.ca

The Claimant shall obtain and bear the cost of obtaining all copies of Supporting Documentation and submitting such copies to the Claims Administrator. Please keep copies of all documentation you send to the Claims Administrator. Completing the documentation process takes time. **ACT NOW**. Do not wait until the last few weeks before the Claim Deadline.

A Medical Direction Form is included at the back of this Claims Package. All Claimants must complete this Form i.e. Primary Claimants or persons acting on behalf of the Primary Claimant, for the purpose of allowing the Claims Administrator to execute the Audit Provisions as defined in Schedule "G", to the Settlement Agreement.

Summary of the Settlement Agreement:

- Claimants may be eligible to receive settlement payments if they ingested Zyprexa on or before June 6, 2007 and then suffered an injury identified in the Settlement Agreement, including diabetes, hyperglycemia, ketoacidosis or pancreatitis.
- An Eligible Primary Claimant is defined as a resident in Canada who was prescribed and ingested the atypical antipsychotic medication Zyprexa, at any time on or before June 6, 2007 and meets one or more of the following criteria.

  (a) Ingested Zyprexa for at least 90 days, and was first diagnosed with diabetes while taking Zyprexa or within one year of his/her last ingestion of Zyprexa; or

  (b) Ingested Zyprexa for at least 90 days, was previously diagnosed diabetic, and while taking Zyprexa or within 60 days of the last Zyprexa use, underwent a clear change in the therapy for diabetes, meaning that the person underwent a change either:

    (i) from diet and exercise therapy to requiring oral hypoglycaemic agents, or

    (ii) from requiring oral hypoglycaemic agents only to requiring insulin with or without oral hypoglycaemic agents

  (c) Ingested Zyprexa for at least 90 days, and was first diagnosed with hyperglycemia while taking Zyprexa or, within one year of his/her last ingestion of Zyprexa. Hyperglycemia means impaired fasting glucose (IFG), identified by a FPG reading of 6.1 mmol/L to 6.9 mmol/L and 2hPG in a 75-g OGTT of 7.8 mmol/L to 11.0 mmol/L, and requires proof at least two lab tests, or,

  (d) Ingested Zyprexa for at least 90 days and was first diagnosed with diabetic ketoacidosis while taking Zyprexa or, within one year of his/her last ingestion of Zyprexa; or,

  (e) Ingested Zyprexa for at least 90 days, and was first diagnosed with pancreatitis while taking Zyprexa or, within one year of his/her last ingesting of Zyprexa

- Derivative Claimants may be eligible to receive settlement payments based upon various factors, including their personal relationship with the Primary Claimant and the size of the payment made to the relevant Primary Claimant.
- The size of the payments will be based on the total number of approved claims and the severity of injuries

Opting Out:

The Opt Out deadline for persons residing in all provinces except British Columbia has passed.

All persons who come within the class definition in British Columbia, are automatically included in the class unless they exclude themselves from the class ("Opt Out"). To Opt Out, a British Columbia Class Member will have to complete, sign and return an "Opt Out Form" postmarked or deposited with the Claims Administrator by courier on or before September 28, 2010. If a British Columbia Class Member does not timely and properly Opt Out and does not timely and properly make a claim under the Settlement Agreement, he or she will be forever barred from receiving any payments under the Settlement Agreement, and from instituting or continuing any action against the Defendants and/or Released Parties related to the use of Zyprexa.

Opt Out forms may be obtained by contacting the Claims Administrator.

Product Identification Documentation shall consist of:

Proof of Zyprexa Ingestion:

Proof that Zyprexa was ingested for at least 90 days during the class period (any time on or before June 6, 2007), consisting of:

(a) pharmacy records, or

(b) medical records reflecting a prescription for Zyprexa; or

(c) if both (a) and (b) are not available, a written statement signed by the treating physician stating that the Primary Claimant was provided or prescribed Zyprexa and on what date such provision or prescription was made. Such statement cannot rest upon unacceptable and insufficient proof (see below) and it must be accompanied by an affidavit from the Primary Claimant or Representative Claimant stating:

- The steps taken by the Claimant to obtain Product Ingestion Documentation as outlined in (a) and (b) above; and

- The responses, if any, to those steps

(d) if unable to provide Product Ingestion Documentation as outlined in (a), (b) or (c) above, the Claimant may submit such other objective verification of the ingestion of Zyprexa as may be acceptable to the Claims Administrator. Such objective verification cannot rest upon unacceptable and insufficient proof as described below. Such other objective verification must be accompanied by an affidavit from the Claimant or Representative Claimant stating:

- The steps taken by the Claimant to obtain Product Ingestion Documentation as outlined in (a), (b) and (c) above; and

- The responses, if any, to those steps

Unacceptable Product Ingestion Documentation:

Your claim will be REJECTED if you do not submit the required Product Ingestion Documentation establishing that the Primary Claimant ingested Zyprexa for at least 90 days during the Class Period.

The following evidence shall be deemed to be **unacceptable** Product Ingestion Documentation:

(a) statements from medical personnel describing their typical or general practices during a given time period, or a statement from the Primary Claimant or Representative Claimant or any other person that seeks to verify Zyprexa ingestion based upon recollection;

(b) records, statements or other terminology which does not specifically identify Zyprexa as the drug prescribed.

The above is intended to be representative of unacceptable proof of product ingestion, without limiting the unacceptable nature of other types of evidence as the Claims Administrator shall determine.

Supporting Documentation:

In addition to the Zyprexa Product Ingestion Documentation identified above, additional Supporting Documentation **must be** provided as follows:

(a) Adverse Events

Medical records from a treating physician demonstrating diagnosis and/or treatment for one or more of the following:

- Hyperglycemia
- Diabetes – no medication necessary
- Diabetes – oral medication necessary
- Diabetes – insulin dependant
- Diabetic Coma or Death
- Aggravation of pre-existing diabetes (as defined in the Settlement Matrix)
- Diabetic Ketoacidosis
- Pancreatitis

Medical records from a treating physician demonstrating development of one of the following serious secondary injuries flowing directly from diabetes

- Blindness
- Amputation
- Renal Failure
- Stroke
- Heart Attack

(b) Exceptional Circumstances

The Claims Administrator may, at his or her discretion, in exceptional circumstances, provide compensation to any person who is otherwise an Eligible Claimant for substantiated circumstances evidencing hardship not otherwise provided for in the Settlement Matrix, as set out Schedule B of the Settlement Agreement. Claimants are required to provide details and sufficient proof of loss with respect to any other special circumstances such as serious economic loss flowing from a diabetic injury or serious secondary injury flowing from diabetes, not already captured in the above list. Eligible Claimants are required to provide sufficient proof that the loss is caused by the diabetic injury or serious secondary injury and not from the underlying condition or illness for which the Claimant was taking Zyprexa.

If the Claimant is unable to obtain the documentation described above through the exercise of reasonable efforts, the Claims Administrator shall have the right to consider other supporting documentation. The Claimant shall obtain and shall bear the cost of obtaining copies of all supporting documentation and submitting such copies to the Claims Administrator. If the supporting documentation and the claim form and other submissions from the Claimant establish the Primary Claimant's condition and loss to the satisfaction of the Claims Administrator, the Claimant shall be entitled to receive the appropriate benefits.

Derivative Claimant Settlements

"Derivative Claimants" means all residents of Canada asserting the right to sue the Defendants or any Released Party independently or derivatively by reason of their familial relationship to a Primary Claimant as defined herein, and shall mean for the purposes of this Settlement Agreement, spouses, common-law spouses, same-sex partners, children, and parents of Primary Claimants.
Children of Eligible Primary Claimants who are under the age of 18 on the date of the adverse event suffered by the Eligible Primary Claimant, and spouses of Eligible Primary Claimants (including common-law and same-sex), shall receive 8% of the amount awarded to the related Eligible Primary Claimant, subject to complete supporting documentation and the Maximum Derivative Claimant Payment as described below.

All other Derivative Claimants (parents and children 18 or over) shall receive 2% of the amount awarded to the related Eligible Primary Claimant, subject to complete supporting documentation and the Maximum Derivative Claimant Payment as described below.

Supporting Documentation for Derivative Claimants

In order to be eligible for compensation, Derivative Claimants must complete the Derivative Claim Form and proof of one's relationship to the Eligible Primary Claimant is required. For example:

- Spouses must provide a copy of their marriage certificate or other document evidencing the relationship to the Eligible Primary Claimant;

- Children of Eligible Primary Claimants must provide a birth certificate or other relevant documentation which establishes the date of birth of the Derivative Claimant, and, if the last name of the child is different from that of the Eligible Primary Claimant, documentation which establishes that the Derivative Claimant is the child of the Eligible Primary Claimant.

Maximum Derivative Claimant Payments per Family

In the event that an Eligible Primary Claimant has Derivative Claimants eligible for benefits the total of which benefits would exceed 20% of the amount awarded to the related Eligible Primary Claimant, the total benefits paid to the Eligible Derivative Claimants shall be divided on a pro-rata basis with the total derivative payments equal to 20% of the amount awarded to the related Eligible Primary Claimant.

Derivative Claimant Settlement Payment Provisions

- Compensation which is payable to a Derivative Claimant who is a child of an Eligible Primary Claimant who is, at the time of payment, is 18 years of age or older, shall be paid directly to the said claimant.

- For Eligible Derivative Claimants who are under the age of 18 years at the time of payment, payments under $5,000.00 shall be paid to the related Eligible Primary Claimant or Representative Claimant in trust, while payments of $5,000.00 or more shall be paid into Court unless otherwise ordered by the Court.

Technical Deficiencies in Claim Form Submissions

a) If, during Claims processing, the Claims Administrator finds that technical deficiencies exist in a Claimant's Claim Form or Supporting Documentation that precludes the proper processing of such Claim, the Claims Administrator shall notify the Claimant via first class regular mail of the technical deficiencies, and shall allow the Claimant forty-five (45) days from the mailing of such notice to correct the deficiencies. If the deficiencies are not corrected within the forty-five (45) day period, the Claims Administrator shall reject the claim. The Claimant will have no further opportunity to correct the technical deficiency.

b) Technical deficiencies referred to above shall not include missing deadlines for submitting Claim Forms, or failing to file sufficient Supporting Documentation to support the Claim which has been made.

Appeal of Claims Decisions

The Claims Administrator shall notify a Claimant of the Administrator's final decision with respect to the disposition of their Claims and the points for which the Claimant is eligible via regular mail directed to their last mailing address provided by the Claimant to the Claims Administrator.

Claimants will be granted a forty-five (45) day period from the date of mailing of such notification to appeal the classification or rejection of their claim. No appeal is available with respect to Claims for Discretionary Points. All appeals will be on the basis of written submissions only, with reference only to material previously provided to the Claims Administrator.

All appeals will be determined by the Courts. Appeals by or in respect of Claimants normally resident in Quebec shall be to the Quebec Court. Appeals by or in respect of Claimants normally resident in British Columbia shall be to the British Columbia Court. Appeals by or in respect of Claimants in a province or territory other than in Quebec or in British Columbia shall be to the Ontario Court. The Courts may appoint referees to review and make recommendations on all appeals. If referees are appointed their reasonable costs shall be paid from the settlement funds. The judgment of the Courts respecting any appeal from the Claims Administrator's decision is final and binding and shall not be the subject of any further appeal or revision.

ZYPREXA POINT DISTRIBUTION MATRIX FOR ELIGIBLE PRIMARY CLAIMANTS

SECTION 1 - INJURY (can only choose one, if qualify for more than one, choose the one with the higher value)	**POINTS ALLOCATED**
Hyperglycemia	10
Diabetes – no medication necessary	40
Diabetes – oral hypoglycaemic agent required	70
Diabetes – insulin dependant	100
Diabetic Coma or Death	150
Aggravation of pre-existing diabetes	20
Diabetic Ketoacidosis	20
Pancreatitis	20
SECTION 2 – SERIOUS SECONDARY INJURIES	
Developed one of the following serious secondary injuries flowing directly from diabetes:	If one or more of these conditions developed, add 100 points
Blindness	
Amputation	
Renal Failure	
Stroke	
Heart Attack	
SECTION 3 – DATE OF FIRST PRESCRIPTION	
Between January 1, 2000 and December 31, 2003	Multiply total points after Section 2 by 2
SECTION 4 – EXCEPTIONAL CIRCUMSTANCES	
Discretionary Points: The Claims Administrator may in its discretion award up to 50 points for substantiated circumstances evidencing hardship that are not otherwise provided for in the Point Distribution Matrix.	Up to 50 points

IMPORTANT DEADLINES

September 28, 2010	Deadline for British Columbia Claimants to Opt Out of the Settlement Agreement
October 28, 2010	Deadline to File a Claim

Opt Out Forms can be downloaded from www.zyprexasettlement.ca or by calling the Claims Administrator at 1-877-739-8933

ALL REQUIRED CLAIM FORMS, SUPPORTING DOCUMENTATION AND OPT OUT FORMS MUST BE SUBMITTED BY THE ABOVE LISTED DEADLINES TO:

Zyprexa Claims Administrator
Suite 3-505 133 Weber St.
Waterloo, Ontario N2J 3G9
1-877-739-8933
www.zyprexasettlement.ca

In no event will claims postmarked after October 28, 2010 (End of Claim Period) be considered.

ZYPREXA CLAIM FORM

Strictly Private and Confidential

I am making a claim as a:

- ❑ Zyprexa Primary Claimant: Complete Section 1, go to Section 4 and continue Claim Form
- ❑ Representative of a Zyprexa Primary Claimant: Complete Sections 1 and 2, go to Section 4 and continue Claim Form
- ❑ Derivative Claimant: Complete Sections 1 and 3, Section 4, if applicable, then go to Section 10

Section 1 - Zyprexa Primary Claimant Identification – Must be completed in all cases

Last Name _____ First Name _____Middle Initial _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Work Phone _____

Email _____ Birth Date:_____
mm dd yyyy

Health Card No _____

Date of Death (if applicable):_____ ❑ Death certificate attached
mm dd yyyy

Section 2 - Representative Identification

This section is to be completed only if you are submitting a Claim as Representative Claimant. "Representative Claimant" includes personal representatives, heirs, assigns, and trustees of the Zyprexa Primary Claimant. You MUST complete Section 1 and identify the Zyprexa Primary Claimant who is your source of entitlement to make a claim. You MUST provide proof of your authority to act as a Representative of a Zyprexa Primary Claimant.

I am applying on behalf of an applicant who is
- ❑ a minor ❑ Authority to Act Enclosed
- ❑ an incapable person ❑ Authority to Act Enclosed
- ❑ an Estate ❑ Authority to Act Enclosed

Please attach a copy of the Court Order or other official document(s) or a copy certified to be a true copy by a lawyer or notary or such other proof of your right to act for the class member and check the box above describing the person you represent.

Rep Last Name _____First Name_____ Middle Initial _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Work Phone _____

Email _____ Birth Date:_____
mm dd yyyy

Section 3 – Derivative Claimant Identification

This section is to be completed only if you are submitting a Claim as a Derivative Claimant. "Derivative Claimant" means spouses, common-law spouses, same-sex partners, as well as parents, and children by birth, marriage or adoption. Please include document(s) demonstrating proof of relationship; i.e. marriage certificate, birth certificate, baptismal papers, separation agreement, custody judgment, divorce judgment, affidavit.

Before completing this section, you MUST complete Section 1 and identify the Zyprexa Primary Claimant who is your source of entitlement to make a claim.

Relationship to Zyprexa Primary Claimant _____

Derivative Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ Work Phone _____

Email _____ Birth Date:_____
mm dd yyyy

I have included the following supporting documentation as proof of relationship:

- ❑ Birth Certificate
- ❑ Marriage Certificate
- ❑ Custody Judgment
- ❑ Affidavit
- ❑ Baptismal Certificate
- ❑ Separation Contract
- ❑ Adoption papers
- ❑ Divorce judgment (if you are in a common-law relationship and were previously married)

If you are a Derivative Claimant please proceed go to Section 10 and sign the Claim Form. If you have a Legal Representative please complete Section 4. Please ensure your relationship documentation is enclosed and send this Claim Form to the Claims Administrator.

Section 4 – Legal Representative Identification

This section is to be completed only if a lawyer is representing the applicant.

Law Firm Name _____

Lawyer's Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ Province _____ Postal Code _____

Phone _____ Fax _____

Email _____ Law Society Number _____

Note: If you complete Section 4 above, all correspondence will be sent to your lawyer, who must notify the Claims Administrator of any change in mailing address. If you change lawyers, you must notify the Claims Administrator in writing of the new information.

Section 5 – Eligible Primary Claimant (or Personal Representative)

An Eligible Primary Claimant is a person who meets one or more of the following criteria. Please check (√) all that apply.

The Eligible Primary Claimant

❑ I **DID NOT** ingest Zyprexa for at least 90 Days

❑ I **INGESTED** Zyprexa for at least 90 Days, AND

- ❑ was first diagnosed with diabetes while taking Zyprexa or within one year of his/her last ingestion of Zyprexa; or
- ❑ was previously diagnosed with diabetes, and while taking Zyprexa or within 60 days of the last Zyprexa use, underwent a clear change in the therapy for diabetes, meaning that the person underwent a change either from:
  - ❑ diet and exercise therapy to requiring oral hypoglycaemic agents, OR
  - ❑ from requiring oral hypoglycaemic agents only, to requiring insulin with or without oral hypoglycaemic agents; or
- ❑ was first diagnosed with hyperglycemia while taking Zyprexa or within one year of his/her last ingestion of Zyprexa. Hyperglycemia means impaired fasting glucose (IFG), identified by a FPG reading of 6.1 mmol/L to 6.9 mmol/L, and impaired glucose tolerance (IGT), identified by a FPG less than 6.1 and 2hPG in a 75-g OGTT of 7.8 mmol/L to 11.0 mmol/L, and requires proof of at least two (2) lab tests; or
- ❑ was first diagnosed with diabetic ketoacidosis while taking Zyprexa or within one year of his/her last ingestion of Zyprexa; or
- ❑ was first diagnosed with pancreatitis while taking Zyprexa or within one year of his/her last ingestion of Zyprexa.

Section 6 – Zyprexa Product Ingestion Documentation

❑ **I INGESTED** Zyprexa for at least 90 days before June 6, 2007.

Please check (√) the applicable box(es) and provide the supporting documentation.

❑ Pharmacy records; or

❑ Medical records reflecting a prescription for Zyprexa; or

❑ If pharmacy and medical records are not available:

- ❑ A written statement signed by the treating physician stating that the Primary Claimant was provided or prescribed Zyprexa and on what date such provision or prescription was made (Such statement cannot rest upon unacceptable and insufficient proof.)

AND

- ❑ An affidavit from the Primary Claimant or Representative Claimant stating the steps taken to obtain pharmacy records and medical records and the responses, if any, to those steps; or

❑ If unable to provide the Product Ingestion Documentation outlined above the claimant may submit to the Claims Administrator such other objective verification of the ingestion of Zyprexa. (Such objective verification cannot rest upon unacceptable and insufficient proof.)

- ❑ Objective verification

AND

- ❑ An affidavit from the Primary Claimant or Representative Claimant stating the steps taken to obtain pharmacy records, medical records, and a written statement by the treating physician and the responses, if any, to those steps

AND

- ❑ A sworn statement stating that the Primary Claimant ingested Zyprexa for at least 90 days following the prescription or provision of Zyprexa, and the date(s) on which ingestion occurred.

Section 7 – Supporting Documentation

In addition to the Zyprexa Ingestion Documentation identified above, additional Supporting Documentation MUST be provided. Please check (√) the applicable box(es) and provide the supporting documentation.

Adverse Events

Medical records from a treating physician demonstrating diagnosis and/or treatment for one or more of the following:

❑ Hyperglycemia

❑ Diabetes – no medication necessary

❑ Diabetes – oral medication necessary

❑ Diabetes – insulin dependant

❑ Diabetic Coma or Death

❑ Aggravation of pre-existing diabetes

❑ Diabetic Ketoacidosis

❑ Pancreatitis

Serious Secondary Injuries

Medical records from a treating physician demonstrating development of one of the following serious secondary injuries flowing from diabetes:

❑ Blindness

❑ Amputation

❑ Renal Failure

❑ Stroke

❑ Heart Attack

❑ None

Section 8 – Date of First Zyprexa Prescription

Please indicate the date of your first Zyprexa Prescription:

❑ Prior to January 1, 2000

❑ Between January 1, 2000 and December 31, 2003

❑ After December 31, 2003

❑ After June 6, 2007

Section 9 – Exceptional Circumstances

The Claims Administrator may, at his or her discretion, in exceptional circumstances, provide compensation to any person who is otherwise an Eligible Claimant for substantiated circumstances evidencing hardship not otherwise provided for in the Settlement Matrix.

Please provide details and sufficient proof of loss with respect to any other special circumstances such as serious economic loss flowing from a diabetic injury or serious secondary injury flowing from diabetes, not already captured in the above list.

Eligible Claimants are required to provide sufficient proof that the loss is caused by the diabetic injury or serious secondary injury and not from the underlying condition or illness for which the Claimant was taking Zyprexa.

Section 10 – Claimant Verification Signature

By signing below, you acknowledge and agree to the following:

a) You declare under penalty of perjury that all the information provided and submitted in this Claim Form is true and correct.

b) You are bound by the full and final release of all your claims against Defendants and other Released Parties as set forth in the Settlement Agreement, which are hereby incorporated by reference herein and receipt of benefits under the terms of the Settlement Agreement shall be your exclusive remedy against such Defendants and other Released Parties.

_____

Signature by Claimant or Representative Making This Claim — Date

_____

Print Name

LAWYER'S SIGNATURE (if the claimant is represented by a lawyer)

_____

Lawyer's Signature — Date

Medical Direction Form

I am the:

- ❑ the Eligible Primary Claimant; OR
- ❑ Personal Representative of the Eligible Primary Claimant

I hereby authorize the persons or entities below to disclose/transmit the following information:

- ❑ Pharmacy records
- ❑ Hospital records
- ❑ Test results
- ❑ Clinical records
- ❑ Other (please specify): _____

Relating to the diagnosis, treatment and care of:

_____ Date of birth _____

Name of Primary Claimant **(Month Day Year)**

for examination by the court appointed Zyprexa Settlement Claims Administrator:

Zyprexa Settlement Administrator
c/o Crawford Class Action Services
Suite 3-505, 133 Weber St. North
Waterloo ON N2J 3G9

Name and address of physician, pharmacy and/or Medical facility

Last name _____ First Name _____ Middle Initial _____

Medical Facility _____

Address _____

City _____ Province/Territory _____ Postal Code _____

Specialty _____

Phone _____ Fax _____

Name and address of physician, pharmacy and/or Medical facility

Last name _____ First Name _____ Middle Initial _____

Medical Facility _____

Address _____

City _____ Province/Territory _____ Postal Code _____

Specialty _____

Phone _____ Fax _____

Name and address of physician, pharmacy and/or Medical facility

Last name _____ First Name _____ Middle Initial _____

Medical Facility _____

Address _____

City _____ Province/Territory _____ Postal Code _____

Specialty _____

Phone _____ Fax _____

Name and address of physician, pharmacy and/or Medical facility

Last name _____ First Name _____ Middle Initial _____

Medical Facility _____

Address _____

City _____ Province/Territory _____ Postal Code _____

Specialty _____

Phone _____ Fax _____

Name and address of physician, pharmacy and/or Medical facility

Last name _____ First Name _____ Middle Initial _____

Medical Facility _____

Address _____

City _____ Province/Territory _____ Postal Code _____

Specialty _____

Phone _____ Fax _____

I agree to waive any right of action against any person or institution for providing information to the Claims Administrator relating to the diagnosis, treatment and care of the Primary Claimant in compliance with this authorization.

_____ _____

Date signed (month day year) Signature of Primary Claimant or Personal Representative