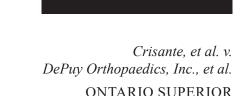
Claims Administrator P.O. Box 4454, Toronto Station A 25 The Esplanade Toronto, ON M5W 4B1





DePuy Orthopaedics, Inc., et al.

ONTARIO SUPERIOR
COURT OF JUSTICE
Civil Action No. CV-10-415777-00CP

Must Be Postmarked No Later Than March 14, 2022

FAMILY CLAIMANT FORM

Canadian National DePuy ASR Hip Implant Class Action

This form must be completed and submitted to the Claims Administrator by e-mail or mail postmarked **no later than March 14, 2022 at the following address:**

info@DePuyASRClassAction.ca P.O. Box 4454, Toronto Station A 25 The Esplanade, Toronto, ON M5W 4B1

FAILURE TO SUBMIT YOUR CLAIM FORM BY THE DEADLINE WILL LEAD TO THE AUTOMATIC REJECTION OF YOUR CLAIM

I am making a claim:

- as a Family Claimant who has a relationship with an individual who
 - a.) has been implanted with one of more ASR Implants; and
 - b.) is making a claim under this settlement ("Claimant")

Section A: Family Claimant Information

First Name	M.I.	Last Name
MM/DD/YYYY		
Date of Birth	Gender	
Primary Address		
City		Province Postal Code
Daytime Phone Number		Cellular Phone Number
Email Address		



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Section B: Claimant Information

I have confirmed with the Claimant that they are making a claim for compensation under this Settlement relating to their injuries from the ASR Implant and that they will/have designate(d) me as their Family Claimant in Section K of their Claim Form.
Yes No
If you checked "No", please do the above before submitting this Family Claimant Form.
If the Claimant does not submit their own claim under this settlement, the Family Claimant is not eligible for any compensation.
Please provide the name and contact information of the Claimant who was implanted with the ASR Implant for whom you are the Family Claimant below:
First Name M.I. Last Name
MM/DD/YYYY
Date of Birth Gender
Primary Address
City Province Postal Code
Daytime Phone Number Cellular Phone Number
Email Address
The Claimant listed above is my:
Spouse Parent Sibling Grandparent Child Grandchild
Section C: Family Claimant Declaration
I solemnly declare that:
I wish to make a claim for compensation in this class action.
I am a family member [spouse, child, grandchild, parent, grandparent, brother, or sister] of the Claimant who has/had a close relationship with the Claimant at the time of their Revision Surgery, and I incurred expenses in caring for the Claimant, and/or experienced a negative impact on my relationship with the Claimant (i.e., loss of guidance, care, and/or companionship) as a result of the Claimant's Revision Surgery.
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 Family Claimant: Dated (mm/dd/yyyy):
Printed Name of Family Claimant:

We strongly recommend that you keep a photocopy of your complete claim for your records.

