Appendix B

Application Form

ROYAL BOTANICAL GARDENS'
MOTHER'S DAY BRUNCH
SALMONELLA CLASS ACTION
APPLICATION FORM

A separate Application Form must be submitted for each Class Member and Family Class Member. If more than one person in your family or party was infected, a separate Application Form must be completed for each individual.

PLEASE SEND THIS COMPLETED APPLICATION FORM by mail, fax or courier to Kerygma Reconciliation, 3425 Harvester Road, Suite 205, Burlington, Ontario, L7N 3N1, fax 905-632-8200, by December 1, 2006.

NOTE: If your Application Form is not submitted on time, you will lose your right to make a claim for benefits under the Agreement.

CLASS MEMBER INFORMATION

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

NAME	
ADDRESS	
CITY	
PROVINCE	
POSTAL CODE	
BIRTH DATE (y/m/d)	
HOME TELEPHONE NUMBER	
WORK TELEPHONE NUMBER	
MOBILE TELEPHONE NUMBER	
E-MAIL ADDRESS	

REPRESENTATIVE INFORMATION

Complete this Section only if you are acting as the Representative of a person under a disability, if you are the custodian of a claimant under 19 years of age or if you are acting in some representative capacity.

NAME	
ADDRESS	
CITY	
PROVINCE	
POSTAL CODE	
BIRTH DATE (y/m/d)	
HOME TELEPHONE NUMBER	
WORK TELEPHONE NUMBER	
MOBILE TELEPHONE NUMBER	
E-MAIL ADDRESS	

Your relationship to the Class Member Applicant:

Parent of a minor ☐

Guardian ☐

Representative ☐

Other _____

QUESTIONS

1. Were you in attendance at the Royal Botanical Gardens' Mother's Day Brunch, May 8, 2005?

   YES ☐

   NO ☐

2. Did you eat at the Brunch?

   YES ☐

   NO ☐

3. Were you ill shortly after the Brunch?

YES ☐

NO ☐

4. When did your symptoms begin (time and date)?

_____

5. What symptoms did you experience as a result of your illness (describe in as much detail how you felt and the symptoms you experienced)?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

6. How long did you experience these symptoms (how long were you ill/sick)?

_____

_____

_____

_____

_____

_____

7. Did you seek out or obtain any medical treatment?

YES ☐

NO ☐

8. If the answer to questions 7 above is “yes”, please indicate in as much detail as possible the medical treatment you obtained including the name, address, etc., of the doctor and when and where you obtained medical treatment?

9. Were you admitted to Hospital?

YES ☐

NO ☐

10. If the answer to questions 9 above is “yes”, please indicate the name, address, etc., of the Hospital, number of days in Hospital, do you have hospital records showing dates, times, place and reason for your admission to hospital?

_____

_____

_____

_____

_____

_____

11. Have you given authorization to Class Counsel to obtain your medical records?

YES ☐

NO ☐

12. If yes, do you authorize Class Counsel to forward your medical records to the Adjudicator?

YES ☐

NO ☐

13. Are you applying for reimbursement for out-of-pocket expenses (including time off work)?

YES ☐

NO ☐

14. List any out-of-pocket expenses that you are claiming and attach available receipts.

EXPENSE DETAILS	**AMOUNT CLAIMED**

15. If you were unable to work because of illness, how many days were you off work?

_____

16. What was your loss of income?

$_____

17. Did you use available sick leave time from your employer in respect of this illness:

YES ☐

NO ☐

18. Did you have available to you sick leave time with your employer but elected not use it?

YES ☐

NO ☐

19. Did you receive reimbursement for any of the out-of-pocket expenses you are claiming as referenced above (from any source, including your employer, benefit plan, insurance coverage, etc.)

YES ☐

NO ☐

If yes, please provide details:

_____

_____

_____

_____

20. What is your occupation?

_____

21. Where did you work?

_____

22. Provide your supervisor's name and telephone number?

_____

_____

_____

FAMILY CLASS MEMBER CLAIMS

This section is to be completed by a partner, spouse, child, grandchild, parent,

grandparent or sibling of a Class Member, where the individual applying claims to have been deprived of the care, companionship, guidance, etc. of the person who was ill following the RBG Mother's Day Brunch.

IT DOES NOT COVER claims by individuals who cared for a family member who was ill.

FAMILY CLASS MEMBER INFORMATION

This information must be provided for each Family Class Member. Please answer all of the questions. Add extra pages if you require more space.

NAME	
ADDRESS	
CITY	
PROVINCE	
POSTAL CODE	
BIRTH DATE (y/m/d)	
HOME TELEPHONE NUMBER	
WORK TELEPHONE NUMBER	
MOBILE TELEPHONE NUMBER	
E-MAIL ADDRESS	

REPRESENTATIVE INFORMATION

Complete this Section only if you are acting as the Representative of a person under a disability, if you are the custodian of a claimant under 19 years of age or if you are acting in some representative capacity.

NAME	
ADDRESS	
CITY	
PROVICE	
POSTAL CODE	
BIRTH DATE (y/m/d)	
HOME TELEPHONE NUMBER	
WORK TELEPHONE NUMBER	
MOBILE TELEPHONE NUMBER	
E-MAIL ADDRESS	

23. What is your relationship to a Class Member who has made an application for compensation?

Partner ☐

Spouse ☐

Child ☐

Grandchild ☐

Parent ☐

Grandparent ☐

Sibling ☐

24. Name of primary Class Member who made an application for compensation?

_____

25. Was the Class Member in attendance at the Royal Botanical Gardens' Mother's Day Brunch, May 8, 2005?

YES ☐

NO ☐

26. Did the Class Member eat at the Brunch?

YES ☐

NO ☐

27. Was the Class Member ill shortly after the Brunch?

YES ☐

NO ☐

28. Were you deprived of the care, companionship, guidance, etc. of the primary Class Member for a period of time ?

YES ☐

NO ☐

29. Provide details of your experience, i.e., specifics as to how you were deprived of the care, companionship, guidance, etc. of the primary Class Member in as much detail as possible. Provide details as to how long this lasted.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

30. Are you applying for reimbursement for any out-of-pocket expenses incurred on behalf of the Class Member?

YES ☐

NO ☐

31. List any out-of-pocket expenses that you are claiming and attach available receipts.

EXPENSE DETAILS	**AMOUNT CLAIMED**

32. Did you receive reimbursement for any of the out-of-pocket expenses you are claiming as referenced above (from any source, including your employer, benefit plan, insurance coverage, etc.)

YES ☐

NO ☐

If yes, please provide details:

_____

_____

_____

_____

I DO HEREBY SOLEMN DECLARE that all the information provided in this completed Application Form as set out above is true and accurate to the best of my knowledge, information and belief and knowing that it is of the same force and effect as if made under oath.

DECLARED BEFORE ME at the City of Hamilton, Province of Ontario this _____ day of _____, 2006.

_____ _____

Commissioner for Taking Affidavits (or as may be)