SCHEDULE D

DAYA CLASS ACTION SETTLEMENT

LONGFORM CLAIM APPLICATION PACKAGE

THE FINAL DATE FOR SUBMISSION OF THE LONGFORM CLAIM FORM AND THE REQUIRED SUPPORTING DOCUMENTATION IS MAY 30, 2008

CLASS ACTION FILE #04-CV-281230CM

DAYA CLASS ACTION SETTLEMENT LONGFORM CLAIM APPLICATION PACKAGE

THIS LONGFORM CLAIM APPLICATION PACKAGE CONTAINS:

- Summary of Settlement Compensation
- Checklist to ensure you complete the appropriate version of the Claim Form
- General Instructions on Completing the Longform Claim Form and Providing Required Supporting Documentation
- Longform Claim Form
- Physician's Form

SUMMARY OF SETTLEMENT COMPENSATION

- $35,000 for any woman who underwent a Tompkins Metroplasty performed by Dr. Daya at Hamilton Health Sciences Corporation in the period January 1, 1990 to March 31, 2004, inclusive, provided she does not opt out of the class action and provided a Claim Form and all required supporting documentation is submitted to the Administrator by the Claims Bar Date (the "eligible Class Member").
- Up to an additional $20,000 if the Tompkins Metroplasty materially contributed to the eligible Class Member experiencing any of the specific medical complications or interventions listed in Section D of the Longform Claim Form in the indicated timeframe. The amount of the additional compensation will depend upon the nature and number of medical complications or interventions the eligible Class Member experienced, and the number of valid claims for additional compensation by eligible Class Members.
- $2,000 to be divided among the following living members of the eligible Class Member's family who were also alive on the date of the Tompkins Metroplasty (the "Family Class Members"):
  - spouse (married or common-law)
  - parents
  - grandparents
  - children
  - siblings
  - grandchildren
- If the eligible Class Member has a child who was alive on the date of the Tompkins Metroplasty and who is currently under the age of 18, the sum of $250 will be allocated for each minor child's benefit out of the $2000 Family Class Member payment and paid into court until the child reaches age 18.
- If there is a surplus in settlement funds after payment of the compensation as outlined and payment of all counsel and administration costs, the remaining settlement funds will be divided equally among all eligible Class Members.
- For more detailed information, please refer to the Judgment and the Distribution Plan at www.dayaclassaction.com.

CLAIMS BAR DATE

To claim settlement compensation, a completed Claim Form and the required supporting documentation must be submitted to the Administrator **no later than May 30, 2008, or such later date as fixed by the Court:**

by mail to: The Administrator—Daya Class Action
c/o Sutts, Strosberg LLP
600-251 Goyeau Street
Windsor ON N9A 6V4

or by fax to: The Administrator—Daya Class Action
866.316.5308

Failure to submit a Claim Form and the required supporting documentation by May 30, 2008, or such later date as fixed by the Court, will eliminate all rights to claim/receive compensation under this settlement.

PRIVACY STATEMENT

Personal information is collected and retained by the Administrator pursuant to the *Personal Information Protection and Electronics Documents Act*, S.C. 2000, c.5:

- for the purpose of operating and administering this settlement
- to consider and evaluate eligibility under this settlement
- is strictly private and confidential and will not be disclosed, except as provided for in this settlement without the express written consent of the person who submitted the claim

CHECKLIST TO ENSURE YOU COMPLETE THE APPROPRIATE VERSION OF THE CLAIM FORM

Answer these questions about the person who had the Tompkins metroplasty (the "Class Member")

•	Is the Class Member dead?	☐ **Yes** ☐ **No**
•	Is the Class Member a mentally incapable person?	☐ **Yes** ☐ **No**
•	Does the Class Member have a child who was alive on the date of the Tompkins Metroplasty who is currently under the age of 18?	☐ **Yes** ☐ **No**
•	Does the Class Member have any sibling and/or grandchild who was alive on the date of the Tompkins Metroplasty who is currently under the age of 18?	☐ **Yes** ☐ **No**
•	Does the Class Member have any spouse, child, parent, sibling, grandparent or grandchild who was alive on the date of the Tompkins Metroplasty who is currently a mentally incapable person?	☐ **Yes** ☐ **No**

If you answered "Yes" to any of the above questions complete the Longform Claim Form contained in this package.

If you answered "No" to all of the questions above, do not complete the Longform Claim Form. Instead, complete a Shortform Claim Form. You may print the Shortform Claim Application Package off the Administrator's website at www.dayaclassaction.com or contact the Administrator as follows to have a Shortform Claim Application Package mailed to you:

by mail to:	The Administrator—Daya Class Action c/o Sutts, Strosberg LLP 600-251 Goyeau Street Windsor ON N9A 6V4	or by fax to: or by email to: or by telephone to:	The Administrator—Daya Class Action 866.316.5308 administrator@dayaclassaction.com 800.229.5323 extension 8291

GENERAL INSTRUCTIONS ON COMPLETING THE LONGFORM CLAIM FORM AND PROVIDING THE REQUIRED SUPPORTING DOCUMENTATION

If you are the person who underwent the Tompkins Metroplasty (the "Class Member"), you must:

- Print your name clearly at the top of each page of the Longform Claim Form.
- Complete Section A of the Longform Claim Form.
- Complete Section B of the Longform Claim Form if you have a child who was alive on the date of the Tompkins Metroplasty and who is currently under the age of 18.
- Complete Section C of the Longform Claim Form listing specific family members of the Class Member ("Family Class Members") and designate a Family Class Member to receive the Family Class Member payment in trust for all of the Family Class Members (except for anyone who is under the age of 18 or is a mentally incapable person).
- Family Class Members who are under the age of 18 or are mentally incapable persons must be represented by a qualified representative as set out in Section C of the Longform Claim Form. Have the appropriate Declaration at Section C signed by the qualified representative of the person under age 18 or the mentally incapable Family Class Member.
- Have the Undertaking at Section C signed by the designated Family Class Member if all Family Class Members and the qualified representative of anyone who is under age 18 or is a mentally incapable person agree on how the $2,000 Family Class Member payment will be divided. If there is no agreement, the Arbitrator will decide how to divide the payment among the Family Class Members.
- Complete Section D of the Longform Claim Form only if you are making a claim for additional compensation because the Tompkins Metroplasty materially contributed to your experiencing certain medical complications or interventions within the indicated timeframes.
- Indicate in Section F that you are submitting the required supporting documentation for those Sections you have completed on the Longform Claim Form (see the General Instruction on Required Supporting Documentation below). Sign the Declaration at Section F of the Longform Claim Form certifying that the information contained in the Longform Claim Form is true, accurate and complete.
- If you are making a claim for additional compensation under Section D of the Longform Claim Form, print your name clearly at the top of each page of the Physician's Form and complete Section A of that form, only. Have your physician complete all of the remaining Sections of the Physician's Form.
- Submit the Longform Claim Form, the required supporting documentation and, if applicable, the Physician's Form to the Administrator by May 30, 2008.

If the person who underwent the Tompkins Metroplasty (the "Class Member") is deceased or mentally incapable, the Class Member's qualified representative must:

- Print the name of the person who underwent the Tompkins Metroplasty clearly at the top of each page of the Longform Claim Form.
- Complete Section A of the Longform Claim Form.
- Complete Section B of the Claim Form if the Class Member has a child who was alive on the date of the Tompkins Metroplasty and who is currently under the age of 18.
- Complete Section C of the Longform Claim Form listing certain family members of the Class Member ("Family Class Members") and designate a Family Class Member to receive the Family Class Member payment in trust for all of the Family Class Members (except for anyone who is under the age of 18 or is a mentally incapable person).

- Family Class Members who are under the age of 18 or are mentally incapable must be represented by his/her/their qualified representative as set out in Section C of the Longform Claim Form. Have the appropriate Declaration at Section C signed by the qualified representative of the person under the age of 18 or the mentally incapable person.
- Have the Undertaking at Section C signed by the designated Family Class Member if all Family Class Members and the qualified representative of anyone who is under age 18 or is a mentally incapable person agree on how the $2,000 Family Class Member payment will be divided. If there is no agreement, the Arbitrator will decide how to divide the payment among the Family Class Members.
- Complete Section D of the Longform Claim Form only if you are making a claim for additional compensation because the Tompkins Metroplasty materially contributed to the Class Member experiencing certain medical complications or interventions within the indicated timeframes.
- Complete Section E of the Longform Claim Form with the information about the Class Member's qualified representative.
- Indicate in Section F that you are submitting the required supporting documentation for those Sections you have completed on the Longform Claim Form (see the General Instruction on Required Supporting Documentation below). Sign the Declaration at Section F of the Longform Claim Form certifying that the information contained in the Longform Claim Form is true, accurate and complete.
- If you are making a claim for additional compensation under Section D of the Longform Claim Form, print the Class Member's name clearly at the top of each page of the Physician's Form and complete Section A of the Physician's Form, only. Have the Class Member's physician complete all remaining Sections of the Physician's Form.
- Submit the Longform Claim Form, the required supporting documentation and, if applicable, the Physician's Form to the Administrator by May 30, 2008.

REQUIRED SUPPORTING DOCUMENTATION

- The required supporting documentation is indicated in the various Sections of the Longform Claim Form.
- A photocopy of a Birth Certificate, Health Card, hospital or medical records, or other required supporting documentation is acceptable so long as it is legible.
- If the Class Member's hospital records from Hamilton Health Sciences Corporation are required, you may arrange to obtain them for no charge by calling the Hospital at 866.492.2472.
- Retain a copy of the completed Longform Claim Form, Physician's Form, if applicable, and all required supporting documentation for your records.

If you require assistance regarding completion of the Longform Claim Form or have questions concerning the claim, you may seek assistance from the Administrator by email to administrator@dayaclassaction.com or by calling 800.229.5323 extension 8291, or you may retain legal counsel at your own expense.

DAYA CLASS ACTION SETTLEMENT LONGFORM CLAIM FORM

SECTION A—IDENTIFICATION OF THE CLASS MEMBER

Complete this section about the person who underwent the Tompkins Metroplasty (the "Class Member").

Submit the Class Member's Birth Certificate, Health Card and only that portion of the Class Member's hospital record from Hamilton Health Sciences Corporation that evidences a Tompkins Metroplasty was performed by Dr. Daya and the date of the procedure with this Longform Claim Form.

Last Name _____ File # _____ For Office Use Only

First Name & Initial _____

Other surnames the Class Member has used from the time of the Tompkins Metroplasty to present _____

Current Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Birth Date: Year _____ Month _____ Day _____

Health Card # _____

Home Phone ____ - ____ - ____ Work Phone ____ - ____ - ____

Email Address _____

What was the date of the Tompkins Metroplasty Dr. Daya performed on the Class Member?

_____ (Day) _____ (Month) _____ (Year)

Complete the section below only if the Class Member is represented by legal counsel.

If a Class Member is represented by legal counsel all further communication will be with her legal counsel.

SECTION A – IDENTIFICATION OF THE CLASS MEMBER'S LEGAL COUNSEL, IF APPLICABLE

Name of Law Firm _____

Last Name _____ First Name _____

Address _____

City _____ Province _____ Postal Code _____

Work Phone ____ - ____ - ____ Fax ____ - ____ - ____

Email Address _____

Legal Counsel are advised to review the provisions in the Distribution Plan regarding Counsel Fees and Directions to Pay Counsel Fees.

SECTION B – IDENTIFICATION OF CLASS MEMBER'S CHILDREN UNDER AGE 18

Complete this section if the Class Member has a child who was alive on the date of the Tompkins Metroplasty, and who is currently under the age of 18 years.

If the Class Member has more than one child alive on the date of the Tompkins Metroplasty who is currently under the age of 18 years, copy this page.

Submit the Birth Certificate of each child listed.

Name _____ DOB _____

Relationship to Class Member _____

Current Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Name _____ DOB _____

Relationship to Class Member _____

Current Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Name _____ DOB _____

Relationship to Class Member _____

Current Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Name _____ DOB _____

Relationship to Class Member _____

Current Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

SECTION C - IDENTIFICATION OF FAMILY CLASS MEMBERS

Complete this section about all Family Class Members of the Class Member.

If you need more room to list all Family Class Members, attach a separate sheet.

1. At the time the Tompkins Metroplasty was performed, did the Class Member have any of the following Family Class Members who are still living:

- a spouse (married, or cohabited continuously for not less than 3 years, or in a relationship of some permanence and the parents of a child) ☐ Yes ☐ No
- child of the Class Member who is age 18 or over ☐ Yes ☐ No
- parent ☐ Yes ☐ No
- sibling ☐ Yes ☐ No
- grandparent ☐ Yes ☐ No
- grandchild? ☐ Yes ☐ No

If you answered "Yes" to any part of question 1, complete the information below. If you answered "No" to all of the categories of Family Class Members in question 1, go to Section D of the Longform Claim Form.

2. Identify **all** Family Class Members alive at the time of the Tompkins Metroplasty who are currently alive and fit any of the categories listed in question 1 above.

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

3. Are any of the Family Class Members that you have listed in answer to question 2 currently under the age of 18? ☐ Yes ☐ No

If you answered "Yes" to question 3, provide the following information for each person under age 18.

Name _____ DOB _____

Relationship to Class Member _____

Current Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Name _____ DOB _____

Relationship to Class Member _____

Current Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Name _____ DOB _____

Relationship to Class Member _____

Current Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

If you answered "Yes" to question 3, have the parent(s)/person(s) with custody of each person under age 18 complete the Declaration by the Parent(s)/Person(s) with Custody on page 6. If more than one Declaration is required, copy the Declaration on page 6.

If you answered "Yes" to question 3, you must submit the Birth Certificate of each person under age 18 and the Court Order or Separation Agreement relating to her/his custody, if applicable.

4. Are any of the Family Class Members that you have listed in answer to question 2 mentally incapable persons? ☐ Yes ☐ No

If you answered "Yes" to question 4, indicate the name of each mentally incapable person here:

_____

_____

_____

_____

If you answered "Yes" to question 4, have the qualified representative of each mentally incapable person complete the Declaration by Qualified Representative of a Mentally Incapable Person on page 6. If more than one Declaration is required, copy the Declaration.

If you answered "Yes" to question 4, you must submit the Court Appointment or Certificate of Statutory Guardian of Property of a mentally incapable person or the Continuing Power of Attorney appointing an Attorney for Property of a mentally incapable person.

5. Have **all** Family Class Members (or, if applicable, his/her/their qualified representative(s)) agreed on how to divide the Family Class Member payment among themselves? ☐ **Yes** ☐ **No**

SECTION C – DESIGNATION OF FAMILY CLASS MEMBER

Identify the Family Class Member designated to receive the Family Class Member payment in trust for all Family Class Members (less any amount allocated for anyone under age 18 or any mentally incapable person).

Name of the Family Class Member being designated _____

Current Address _____

City _____ Province _____ Postal Code _____

Home Phone ____ - ____ - ____ Work Phone ____ - ____ - ____

Email Address _____

Relationship to Class Member: _____

SECTION C - UNDERTAKING TO THE COURT BY THE DESIGNATED FAMILY CLASS MEMBER

Have the person designated to receive the Family Class Member payment complete this Undertaking only if all Family Class Members (or, if applicable, his/her/their qualified representative) agree on how to divide the Family Class Member payment.

NOTICE: Any person who submits an Undertaking to the Court containing inaccurate and/or false information to obtain undue benefits under this settlement may be subject to criminal and/or civil action.

I, _____ , am the Family Class Member designated
(Name)

to receive the Family Class Member payment on behalf of all Family Class Members identified in Section C of this Longform Claim Form (except for any amount allocated for anyone under age 18 or any mentally incapable person).

I hereby certify that:

- a division of the Family Class Member payment has been agreed to by all of the Family Class Members identified in Section C of this Claim Form (or his/her/their qualified representative, if applicable);
- I will receive the monies in trust for all of the said Family Class Members (except for anyone under age 18 or any mentally incapable person); and
- I will pay the monies out to the Family Class Members (except for anyone under age 18 or any mentally incapable person) in the amounts we have agreed.

Signed at _____ this _____ of _____ , _____
(City) (Day) (Month) (Year)

_____ _____
Witness Signature

SECTION C – DECLARATION BY THE PARENT(S)/PERSON(S) WITH CUSTODY OF A FAMILY CLASS MEMBER UNDER THE AGE OF 18

I/We, _____, (Name(s))

am/are the parent(s)/person(s) with custody of the Family Class Member listed in Section C who is under the age of 18

_____ (Name of Child)

born on _____ (Day) _____ (Month) _____ (Year)

I/we agree that the amount to be allocated from the $2,000 Family Class Member payment for the benefit of the person under the age of 18 is _____ (insert amount) and hereby acknowledge being advised the monies will be paid into court until the child reaches the age of 18.

Signed at _____ (City) this _____ (Day) of _____ (Month), _____ (Year)

_____ Witness _____ Signature

_____ Witness _____ Signature

SECTION C - DECLARATION BY QUALIFIED REPRESENTATIVE OF A MENTALLY INCAPABLE PERSON

Only the following persons are qualified to represent a mentally incapable person:

- **Guardian of Property**
- **Attorney for Property**

Submit one of the following required supporting documents:

- **Court Appointment or Certificate of Statutory Guardian of Property of a mentally incapable person**
- **Continuing Power of Attorney appointing an Attorney for Property of a mentally incapable person**

I _____, (Name) am the qualified representative of the mentally incapable person

_____ (Name of mentally incapable person) born on _____ (Day) _____ (Month) _____ (Year)

I agree that the amount to be allocated from the $2,000 Family Class Member payment for the benefit of the mentally incapable person is _____ (insert amount) and hereby certify that the payment should be directed to me on her/his behalf.

Signed at _____ (City) this _____ (Day) of _____ (Month), _____ (Year)

_____ Witness _____ Signature

SECTION D - APPLICATION FOR ADDITIONAL COMPENSATION FOR SPECIFIC MEDICAL COMPLICATIONS/INTERVENTIONS

Complete this section only if the Tompkins Metroplasty materially contributed to the Class Member experiencing one or more of the medical complications/interventions listed below. A physician's opinion on causation is required to support the claim.

Indicate all of the listed complications/interventions which apply.

1.	Did the Class Member experience a wound dehiscence (the wound from the Tompkins Metroplasty opened or split) within three months of the Tompkins Metroplasty?	☐ Yes	☐ No
2.	Did the Class Member undergo a D & C (dilation and curettage) for any reason other than an early pregnancy loss within six months of the Tompkins Metroplasty?	☐ Yes	☐ No
3.	Did the Class Member undergo a D & C (dilation and curettage) as a result of an early pregnancy loss within twelve months of the Tompkins Metroplasty?	☐ Yes	☐ No
4.	Did the Class Member undergo an umbilical hernia repair anytime after the Tompkins Metroplasty?	☐ Yes	☐ No
5.	Did the Class Member undergo a hysterectomy anytime after the Tompkins Metroplasty?	☐ Yes	☐ No
6.	Did the Class Member undergo a salpingectomy (removal of fallopian tube) anytime after the Tompkins Metroplasty?	☐ Yes	☐ No
7.	Did the Class Member undergo a laparoscopy to treat an ectopic pregnancy anytime after the Tompkins Metroplasty?	☐ Yes	☐ No
8.	Did the Class Member deliver a stillborn child by caesarian section as a result of premature labour anytime after the Tompkins Metroplasty?	☐ Yes	☐ No
9.	Did the Class Member undergo a surgical repair at any time as a result of the Tompkins Metroplasty?	☐ Yes	☐ No

If you answered "Yes" to one or more of these questions, describe what occurred:

_____

_____

_____

_____

_____

If you answered "Yes" to any of the questions above, you must submit the completed Physician's Form and the supporting hospital or medical records. Include only the portions of the Class Member's hospital or medical records that evidence the medical complication/intervention, the date it occurred and its cause.

SECTION D – APPLICATION FOR ADDITIONAL COMPENSATION FOR SECOND TOMPKINS METROPLASTY

Complete this section only if the Class Member underwent a second Tompkins Metroplasty.

10. Did the Class Member undergo a second Tompkins Metroplasty performed by Dr. Daya in the period January 1, 1990 to March 31, 2004, inclusive? ☐ **Yes** ☐ **No**

11. What was the date of the second Tompkins Metroplasty Dr. Daya performed on the Class Member? ☐ **Yes** ☐ **No**

_____ (Day) _____ (Month) _____ (Year)

If you completed this section, submit only that portion of the Hamilton Health Sciences Corporation hospital record that evidences a second Tompkins Metroplasty was performed by Dr. Daya and the date of the procedure. A completed Physician's Form is not required to confirm a second Tompkins Metroplasty.

SECTION E - IDENTIFICATION OF THE CLASS MEMBER'S QUALIFIED REPRESENTATIVE

Complete this section if you are submitting the Longform Claim Form for a Class Member who is deceased or a mentally incapable person.

Only the following persons are qualified to represent the Class Member:

- **Estate Trustee, if the Class Member is deceased**
- **Statutory Guardian of Property or Attorney for Property, if the Class Member is a mentally incapable person**

Submit the applicable required supporting documentation from the following list with the Longform Claim Form:

- **Death Certificate for the Class Member**
- **Certificate of Appointment as Estate Trustee**
- **Will or Codicil appointing an Estate Trustee**
- **Court Appointment or Certificate of Statutory Guardian of Property of a mentally incapable person**
- **Continuing Power of Attorney appointing an Attorney for Property of a mentally incapable person**

I am applying on behalf of the Class Member who is:

☐ Deceased
☐ A mentally incapable person

Last Name _____

First Name & Initial _____

Current Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Home Phone ____ - ____ - ____ Work Phone ____ - ____ - ____

Email Address _____

SECTION F – REQUIRED SUPPORTING DOCUMENTATION

With this Longform Claim Form I am submitting the following required supporting documentation:

For all persons completing Section A – IDENTIFICATION OF THE CLASS MEMBER.

1.	Birth Certificate of Class Member.	☐ Yes	☐ No
2.	Health Card of Class Member.	☐ Yes	☐ No
3.	The Class Member's hospital records from Hamilton Health Sciences Corporation evidencing the Tompkins Metroplasty and the date it occurred.	☐ Yes	☐ No

For persons Completing Section B – IDENTIFICATION OF CLASS MEMBER'S CHILDREN UNDER AGE 18

4.	Birth Certificate of each minor child of the Class Member alive on the date of the Tompkins metroplasty who is currently under the age 18.	☐ Yes	☐ No

For persons completing Section C – Question 3 only.

5.	Birth Certificate of each person under age 18 who is a Family Class Member.	☐ Yes	☐ No
6.	Court Order or Separation Agreement relating to custody of each Family Class Member who is under age 18, if applicable.	☐ Yes	☐ No

For persons completing Section C – Question 4 only.

7.	Court Appointment or Certificate of Statutory Guardian of Property of a mentally incapable person.	☐ Yes	☐ No
8.	Continuing Power of Attorney appointing an Attorney for Property of a mentally incapable person.	☐ Yes	☐ No

For persons who answered "Yes" to Section D – Questions 1 to 9 only.

9.	Completed Physician's Form.	☐ Yes	☐ No
10.	The Class Member's hospital or medical records evidencing each medical complication/intervention experienced, the date it occurred and its cause.	☐ Yes	☐ No

For persons who answered "Yes" to Section D - Question 10 only.

11.	The Class Member's hospital records from Hamilton Health Sciences Corporation evidencing a second Tompkins Metroplasty and the date it occurred.	☐ Yes	☐ No

For persons completing Section E – CLASS MEMBER'S QUALIFIED REPRESENTATIVE IDENTIFICATION ONLY.

12.	Death Certificate for the Class Member	☐ Yes	☐ No
13.	Will or Codicil appointing an Estate Trustee.	☐ Yes	☐ No
14.	Certificate of Appointment as Estate Trustee.	☐ Yes	☐ No
15.	Court Appointment or Certificate of Statutory Guardian of Property of a mentally incapable person.	☐ Yes	☐ No
16.	Continuing Power of Attorney appointing an Attorney for Property of a mentally incapable person.	☐ Yes	☐ No

SECTION F - DECLARATION OF CLASS MEMBER (OR HER QUALIFIED REPRESENTATIVE IF THE CLASS MEMBER IS DECEASED OR A MENTALLY INCAPABLE PERSON)

NOTICE: Any person who submits a Longform Claim Form to the Administrator containing inaccurate and/or false information to obtain undue benefits under this settlement may be subject to criminal and/or civil action.

I hereby certify that:

- the information I have provided in this Longform Claim Form is, to the best of my knowledge, information and belief, true, accurate and complete; and
- I have listed all of the Family Class Members alive on the date of the Tompkins Metroplasty who are currently alive on this Longform Claim Form.

Signed at _____ (City) this _____ (Day) of _____ (Month), _____ (Year)

_____ Witness

_____ Signature

505186

PHYSICIAN'S FORM

SECTION A - IDENTIFICATION OF PATIENT

Complete this section about the person who underwent the Tompkins Metroplasty (the "Patient").

Last Name _____ First Name & Initial _____

Health Card # _____

Date the Tompkins Metroplasty was performed: _____ (Day) _____ (Month) _____ (Year)

SECTION B – IDENTIFICATION OF PHYSICIAN

Last Name _____ First Name & Initial _____

Address _____

City _____ Province _____ Postal Code _____

Work Phone ____ - ____ - ____ Fax ____ - ____ - ____

Email Address _____ Specialty _____

SECTION C - COMPLICATIONS/INTERVENTIONS EXPERIENCED FOLLOWING A TOMPKINS METROPLASTY

Indicate all of the listed medical complications/interventions experienced by the Patient which were materially contributed to by the Tompkins Metroplasty.

Did the Tompkins Metroplasty **materially contribute** to the Patient experiencing one or more of the following medical complication/interventions in the indicated timeframe:

- wound dehiscence within three months of the Tompkins Metroplasty ☐ **Yes** ☐ **No**
- a D & C for any condition other than an early pregnancy loss within six months of the Tompkins Metroplasty ☐ **Yes** ☐ **No**
- a D & C as a result of an early pregnancy loss within twelve months of the Tompkins Metroplasty ☐ **Yes** ☐ **No**
- an umbilical hernia repair anytime after the Tompkins Metroplasty ☐ **Yes** ☐ **No**
- a hysterectomy anytime after the Tompkins Metroplasty ☐ **Yes** ☐ **No**
- a salpingectomy anytime after the Tompkins Metroplasty ☐ **Yes** ☐ **No**
- a laparoscopy to treat an etopic pregnancy anytime after the Tompkins Metroplasty ☐ **Yes** ☐ **No**
- a delivery of a stillborn child by caesarian section as a result of premature labour anytime after the Tompkins Metroplasty ☐ **Yes** ☐ **No**
- surgical repair at anytime as a result of the Tompkins Metroplasty? ☐ **Yes** ☐ **No**

If you answered "Yes" to any of the questions above, include copies of the Patient's hospital or medical records which support the occurrence of the complication/intervention, its timing and that the Tompkins Metroplasty caused or materially contributed to its occurrence (include only the relevant portions of the hospital or medical records).

If you answered yes to one or more of the indicated complications/interventions, explain how the Tompkins Metroplasty materially contributed to each:

Did you treat the Patient for this/these medical complications / interventions? ☐ Yes ☐ No

If yes, indicate which medical complications/interventions you treated:

If you did not treat the Patient for this/these medical complications/interventions, on what do you base your opinion that the Tompkins Metroplasty materially contributed to the complications/interventions?

How long have you known the Patient? _____ (Years) How long have you treated the Patient? _____ (Years)

SECTION D - CERTIFICATION BY PHYSICIAN

I hereby certify that the information provided herein is true and correct to the best of my knowledge, information and belief.

Signed at _____ (City) this _____ (Day) of _____ (Month), _____ (Year)

_____
Physician's Signature