

Miramichi Pathology Class Action Settlement

www.wagners.co/current-class-actions/miramichi-pathology

CLAIMING INSTRUCTIONS

Your duly completed Claim Form must be submitted **no later than February 26, 2020**. Late claim submissions will not be accepted or valid.

CLAIMING CATEGORY 1A/1B? PLEASE READ THE INSTRUCTIONS BELOW CAREFULLY

STEP 1 <i>Submit a Release of Medical Records Authorization Form for Category 1A/1B</i>	<p>Download the <i>Release of Medical Records Authorization Form</i> on the dedicated website at www.wagners.co/current-class-actions/miramichi-pathology</p> <p>OR</p> <p>Contact the Claims Administrator at the contact information below to request that the form be sent to you via mail or email.</p> <p>The <i>Release of Medical Records Authorization Form</i> must be submitted to the Claims Administrator no later than October 29, 2019.</p> <p>The Claims Administrator shall reject any <i>Release of Medical Records Authorization Form</i> not clearly post marked on or before, or received prior to October 29, 2019.</p> <p>IMPORTANT: The Hospital records may not contain records of your family physician, hospital visits in other provinces, and other records not in the possession of the Horizon Health Authority. You will need to obtain these records on your own.</p>
STEP 2 <i>Determination of Eligibility for Category 1A/1B</i>	<p>The Claims Administrator will determine whether the Class Member is eligible to submit a claim for Category 1A or 1B.</p> <ul style="list-style-type: none">• In the case of eligibility, the Hospital will deliver relevant medical records directly to the Class Member in question, and• In the case of ineligibility, the Claims Administrator will communicate same to the Class Member.
STEP 3 <i>If Deemed Eligible under Category 1A/1B</i>	<p>If the Class Member is deemed eligible to submit a claim for compensation under Category 1A or 1B, on receipt of a copy of their relevant medical records, at no charge to them, an Eligible Class Member must provide to the Claims Administrator a copy of the medical records they deem relevant to their claim for compensation under Category 1A or 1B along with the Category 1A/1B Claim Form.</p> <p>If compensation is approved under Category 1, no Category 2 award is payable.</p> <p>IMPORTANT: Records that have no relevance will not be reviewed. Please <u>only</u> send in relevant records to support your claim for the harm you say you suffered.</p> <p>The Category 1A/1B claim submission must be post marked no later than February 26, 2020.</p> <p>In the event that there is no legible postmark, the claim submission must be received by the Claims Administrator no later than February 26, 2020.</p> <p>The Claims Administrator shall reject any claim submissions not clearly post marked on or before, or received prior to February 26, 2020.</p>

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CLAIMING INSTRUCTIONS (continued)

CLAIMING CATEGORY 2? PLEASE READ THE INSTRUCTIONS BELOW CAREFULLY

<p>Submit a Category 2 Claim Form</p> <p><i>Only if you are only claiming a Category 2 compensation</i></p>	<p>If you are only claiming a Category 2 compensation, all Category 2 claim submissions must be post marked no later than February 26, 2020.</p> <p>If the Class Member is deemed ineligible to submit a claim for compensation under Category 1A or 1B, but the Claims Administrator believes them to meet the criteria for compensation under Category 2 of the Compensation Grid, the claim submission will be assessed at Category 2. Should this be the case the Class Member will not be required to also submit a Category 2 Claim Form to the Claims Administrator.</p> <p>In the event that there is no legible postmark, the claim submission must be received by the Claims Administrator no later than February 26, 2020.</p> <p>The Claims Administrator shall reject any claim submissions not clearly post marked on or before, or received prior to February 26, 2020.</p>
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SUBMITTING INSTRUCTIONS

There are **three (3) ways** to submit a *Release of Medical Records Authorization Form* or claim submission including all relevant medical records:

<p>1. MAIL</p>	<p>Mail your duly complete claim submission to:</p> <p style="text-align: center;">Miramichi Pathology Class Action Claims Administrator Nelson P.O. Box 20187 – 322 Rideau Street Ottawa ON K1N 5Y5</p> <p>Mailed claim submissions must be post marked no later than February 26, 2020.</p> <p>Mailed <i>Release of Medical Records Authorization Form</i> must be post marked no later than October 29, 2019.</p>
<p>2. EMAIL</p>	<p>Email your duly completed claim submission to info@miramichipathologyclassaction.ca</p>
<p>3. FAX</p>	<p>Fax your duly complete claim submission to 1-866-262-0816</p>

Toll-Free Telephone: 1-833-449-4583

Please read the Compensation Grid carefully on page 3 for Category 1A/1B and page 7 for Category 2 before submitting your claim.

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CATEGORY 1A/1B CLAIM FORM

COMPENSATION GRID		
In the event that the Qualified Class Member Payments exceed the Settlement Fund, all Qualified Class Member Payments shall be subject to <i>pro rata</i> reduction.		
Category 1A - Psychiatric or Psychological disturbance arising from change in diagnosis		
Eligibility/Verification Who is eligible to apply	Proof Required	Award
<p>Class Members who had a partial or complete change, as determined by Gamma Dynacare/Dr. Henderson.</p> <p>Eligibility for Category 1A payment verified as follows:</p> <ul style="list-style-type: none"> • Initial pathology testing performed by Dr. Menon for potential cancer or cancer-related disease as determined by the Rokosh Report. • Confirmation from a Hospital representative to the Claims Administrator that the claimant's initial pathology report was reviewed by Gamma Dynacare/Dr. Henderson and noted as a partial or complete change. Initial pathology report with addendum to be provided to the claimant by the Hospital at its own expense, if necessary, as well as any additional relevant hospital records required, upon the written consent for release signed by the claimant. 	<p>Medical records indicating psychiatric or psychological arising directly from change in diagnosis (e.g. treatment sought from GP, specialist). This can include an otherwise unrequired visit to a physician for the purpose of: interpretation of the changed diagnosis, and/or an interpretation of the records by a physician.</p>	<p>\$2,500.00</p>

Important: Records that have no relevance will not be reviewed.

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CATEGORY 1A/1B CLAIM FORM

COMPENSATION GRID (continued)		
Category 1B – Physical and/or Psychological injury caused by discrepancy that has potential to result in medical harm.		
Eligibility/Verification Who is eligible to apply	Categories and Proof Required	Award
<p>Class Members who received a change in diagnosis from Dr. Henderson or Gamma Dynacare and the change had potential to result in medical harm, as determined in the Rokosh Report.</p> <p>Eligibility for Category 1B payment verified as follows:</p> <ul style="list-style-type: none"> Initial pathology testing performed by Dr. Menon for potential cancer or cancer-related disease as determined by the Rokosh Report. Confirmation from a Hospital representative to the Claims Administrator that the claimant's initial pathology report was reviewed by Gamma Dynacare/Dr. Henderson and noted as a partial or complete change. Initial pathology report with addendum to be provided to the claimant by the Hospital at its own expense, if necessary, as well as any relevant hospital records required, upon the written consent for release signed by the claimant. To be verified by Claims Administrator: Rokosh Report categorized change as having potential to result in medical harm. Additional specific eligibility criteria for mild/medium/severe harm subcategories of Category 1B are as described in the adjacent column. 	<p>Mild Harm (one (1) or more of the following)</p> <ul style="list-style-type: none"> Medical records indicating psychiatric or psychological disturbance arising directly from change in diagnosis (e.g. treatment sought from GP, specialist) Medical records indicating later medical consultation or testing was obtained due to change in diagnosis (regardless of the outcome thereof) 	\$10,000.00
	<p>Medium Harm (one (1) or more of the following)</p> <ul style="list-style-type: none"> Overdiagnosis with consultation: Medical records indicating Dr. Menon over-diagnosed, leading to inappropriate and/ or unnecessary medical consultation (but not treatment) Wrong diagnosis: Wrong diagnosis, although it did not lead to a different course of treatment or intervention but led to delay in diagnosis, to a degree that the delay would likely lead to increase in morbidity or mortality 	\$25,000.00
	<p>Severe Harm (one (1) or more of the following)</p> <ul style="list-style-type: none"> Missed cancer: Missed malignancy or pre-malignancy (failure to identify a malignancy or pre-malignancy later identified by Gamma Dynacare) that led to delay in diagnosis, to a degree that the delay would likely lead to increase in morbidity or mortality Overdiagnosis with treatment: Medical records indicating Dr. Menon overdiagnosed, leading to inappropriate and/or unnecessary medical treatment (Dr. Menon's diagnosis exceeded, in severity, the diagnosis subsequently provided by Gamma Dynacare) Wrong diagnosis that led to a different course of treatment or intervention 	\$50,000.00

Important: Records that have no relevance will not be reviewed.

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CATEGORY 1A/1B CLAIM FORM

SECTION A: CLAIMANT NAME AND CURRENT CONTACT INFORMATION

The Claims Administrator will use the information that you provide to process your claim. If this information changes, you **MUST** notify the Claims Administrator in writing.

<input type="text"/>	<input type="text"/>	
First Name	Last Name	
<input type="text"/>		
Street Address		
<input type="text"/>	<input type="text"/>	<input type="text"/>
City	Province	Postal Code
<input type="text"/>		<input type="text"/>
Email		Telephone

SECTION B: PATIENT IDENTIFICATION INFORMATION

<input type="text"/>	<input type="text"/>
Date of Birth (Month Day, Year)	Health Medicare Number
<input type="text"/>	
Date tissue samples underwent pathology testing (Month Day, Year)	

SECTION C: AUTHORITY TO CLAIM ON BEHALF OF THE PATIENT

IMPORTANT: CLAIMS ON BEHALF OF ESTATES OF DECEASED CLASS MEMBERS ARE PERMITTED ONLY IF THE CLASS MEMBER DIED *AFTER JULY 4, 2019*. IF THE CLASS MEMBER DIED *BEFORE JULY 4, 2019*, NO ESTATE CLAIM IS ELIGIBLE AND YOU WILL NOT RECEIVE COMPENSATION.

Complete this section if you are NOT the Claimant.

<p>Please indicate your relationship to the Patient</p> <p><input type="checkbox"/> Estate Trustee/Executor (if Claimant died after July 4, 2019)</p> <p><input type="checkbox"/> Power of Attorney</p> <p><input type="checkbox"/> Other: _____</p>	<p>I have enclosed the following documentation as proof of my authority to submit this claim on behalf of the Patient</p> <p><input type="checkbox"/> Last Will of the Donor (if Claimant died after July 4, 2019)</p> <p><input type="checkbox"/> Appointment of Estate Trustee (if Claimant died after July 4, 2019)</p> <p><input type="checkbox"/> Power of Attorney</p> <p><input type="checkbox"/> Other: _____</p>
<p>Your First Name: _____</p> <p>Your Last Name: _____</p> <p>Your Contact Telephone Number: _____</p> <p>Your Email Address: _____</p> <p>Your Full Address: _____</p>	

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CATEGORY 1A/1B CLAIM FORM

SECTION D: COMPENSATION UNDER CATEGORY 1A OR 1B

Please check the box below to indicate which category you are claiming for under this class action settlement. **Please read the Compensation Grid carefully on page 3 and 4.**

- ☐ **Category 1A** - \$2,500.00 Award
- ☐ **Category 1B** – Mild Harm - \$10,000.00 Award
- ☐ **Category 1B** – Medium Harm - \$25,000.00 Award
- ☐ **Category 1B** – Severe Harm - \$50,000.00 Award

Important: If it is determined that you are ineligible for the compensation that you are claiming, your claim will be assessed at the category deemed appropriate.

SECTION E: SOLEMN DECLARATION

I solemnly declare that I have read and understand the contents of this Claim Form. I declare under penalty of perjury that the statements I have made in this Claim Form are true, correct and complete to the best of my knowledge, information and belief.

Executed on _____, in _____, _____
Date (Month Day, Year) City Province

Claimant Printed Name

Claimant Signature

Witness Printed Name

Witness Signature

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www.wagners.co/current-class-actions/miramichi-pathology

CATEGORY 2 CLAIM FORM

COMPENSATION GRID	
Category 2 – Payment for partial or complete change	
Eligibility/Verification Who is eligible to apply	Award
<p>Class Members who had a partial or complete change, as determined by Gamma Dynacare/Dr. Henderson, but do not receive compensation under Category 1. If compensation is received under Category 1, no Category 2 award is payable.</p> <p>Eligibility verified as follows:</p> <ul style="list-style-type: none">Initial pathology testing performed by Dr. Menon for potential cancer or cancer-related disease as determined by the Rokosh Report Confirmation from a Hospital representative to the Claims Administrator that the claimant's initial pathology report was reviewed by Gamma Dynacare/Dr. Henderson and noted as a partial or complete change. Initial pathology report with addendum to be provided to the claimant by the Hospital at its own expense, if necessary, and upon the written consent for release signed by the claimant.	<p>Maximum of \$750.00 per person (net of legal fees/notice/claims administration costs)</p>
<p>In the event that the Qualified Class Member Payments exceed the Settlement Fund, all Qualified Class Member Payments shall be subject to <i>pro rata</i> reduction.</p>	

Important: Records that have no relevance will not be reviewed.

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CATEGORY 2 CLAIM FORM

SECTION A: CLAIMANT NAME AND CURRENT CONTACT INFORMATION

The Claims Administrator will use the information that you provide to process your claim. If this information changes, you **MUST** notify the Claims Administrator in writing.

<input type="text"/>	<input type="text"/>	
First Name	Last Name	
<input type="text"/>		
Street Address		
<input type="text"/>	<input type="text"/>	<input type="text"/>
City	Province	Postal Code
<input type="text"/>		<input type="text"/>
Email		Telephone

SECTION B: PATIENT IDENTIFICATION INFORMATION

<input type="text"/>	<input type="text"/>
Date of Birth (Month Day, Year)	Health Medicare Number
<input type="text"/>	
Date tissue samples underwent pathology testing (Month Day, Year)	

SECTION C: AUTHORITY TO CLAIM ON BEHALF OF THE PATIENT

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<p>Your First Name: _____</p> <p>Your Last Name: _____</p> <p>Your Contact Telephone Number: _____</p> <p>Your Email Address: _____</p> <p>Your Full Address: _____</p>	

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CATEGORY 2 CLAIM FORM

SECTION D: SOLEMN DECLARATION

I solemnly declare that I have read and understand the contents of this Claim Form. I declare under penalty of perjury that the statements I have made in this Claim Form are true, correct and complete to the best of my knowledge, information and belief.

Executed on _____, in _____, _____
Date (Month Day, Year) City Province

Claimant Printed Name

Claimant Signature

Witness Printed Name

Witness Signature