Wright Profemur Hip Implant Class Action
Claims Administrator
P.O. Box 4454
Toronto Station A 25 The Esplanade
Toronto, ON M5W 4B1

WRQ

RODRICK DESBOROUGH V. WRIGHT MEDICAL TECHNOLOGY CANADA LTD. ET AL

SUPREME COURT OF NOVA SCOTIA

HFX. NO. 355381

Must Be Postmarked No Later Than
October 8, 2020

I. CLAIMANT FORM

Wright Profemur Hip Implant System Class Action

This form must be completed and returned to the Claims Administrator by email, mail or in person no later than October 8, 2020.

You will be ineligible to recover under this Settlement Agreement if your Wright Profemur Hip Implant System has not fractured.

I am making a claim either myself or through counsel:

- ○ as a Claimant who was implanted with a Wright Profemur Hip Implant System after February 2001 and has suffered a fracture of the Wright Profemur Hip Implant System(s) on or before August 5, 2020, requiring a revision surgery.
- ○ as the Representative (a person who is the legal representative of a Claimant who is under a legal disability) of a Claimant.

PART I: SECTION A: CLAIMANT INFORMATION

First Name | M.I. | Last Name

MM / DD / YYYY
Date of Birth

Gender: ○ Male ○ Female

Primary Address

Primary Address Continued

City

Province | Postal Code

Email Address

Area Code — Daytime Phone Number | Area Code — Cellular Phone Number

Current Provincial Health Insurance Number (“PHN”)

FOR CLAIMS PROCESSING ONLY	OB	CB	○ DOC ○ LC ○ REV	○ RED ○ A ○ B

Did the Claimant's province of residence change since the time that the Claimant received the Device and suffered a fracture requiring revision surgery?

○ Yes ○ No

If you checked "Yes," please list the Claimant's other province(s) of residence and his/her Provincial Health Insurance Number(s) for those province(s):

Primary Address

Primary Address Continued

City

Province

Postal Code

Provincial Health Insurance Number ("PHN")

Primary Address

Primary Address Continued

City

Province

Postal Code

Provincial Health Insurance Number ("PHN")

PART I: SECTION B: PERSONAL REPRESENTATIVE

Are you completing this form as someone with the legal capacity to act on behalf of the Claimant (i.e., an individual with power of attorney, an estate representative, etc.)?

○ Yes ○ No

If "Yes," please complete the remainder of Section B with information about yourself. If "No," skip to Section C.

First Name | M.I. | Last Name

Primary Address

Primary Address Continued

City

Province | Postal Code

Email Address

Area Code — Daytime Phone Number — | Area Code — Cellular Phone Number —

MM / DD / YYYY

Date of Birth

Gender: ○ Male ○ Female

Relationship to Claimant:

Please attach the documents that grant you the legal authority to act on behalf of the Claimant to this form (i.e., Power of Attorney, Letters of Administration, etc.).

- ○ Power of Attorney
- ○ Certificate of Incapacity
- ○ Letters of Administration
- ○ Other. Please explain _____

PART I: SECTION C: LAWYER INFORMATION (IF APPLICABLE)

This section is to be completed ONLY IF a lawyer or agent is representing the Claimant for the purpose of assisting with and submitting this Claim Form. You are not required to provide the information of Class Counsel in this section if you are submitting your Claim Form on your own or as the Representative of a Claimant, without legal representation.

NOTE: If you complete Section C below, all correspondence will be sent to your legal representative, who must notify the Claims Administrator of any change in mailing address. If you change your legal representation or cease to retain your legal representative, you must notify your former legal representative and the Claims Administrator in writing.

Lawyer First Name

Lawyer Last Name

Name of Law Firm

Primary Address

Primary Address Continued

City

Province

Postal Code

Email Address

Area Code — Daytime Phone Number

Area Code — Facsimile Phone Number

PART I: SECTION D: WRIGHT PROFEMUR HIP IMPLANT SYSTEM INFORMATION

Location of the Wright Profemur Hip Implant System: ○ Right ○ Left ○ Bilateral

Implant Date (**Right**): M M / D D / Y Y Y Y

Name of Hospital

Surgeon

Implant Date (**Left**): M M / D D / Y Y Y Y

Name of Hospital

Surgeon

Identification stickers and operative report(s) for your Wright Profemur Hip Implant System(s), establishing the implant surgery and subsequent revision surgery, must be submitted with this Claimant Declaration. See Compensation Protocol.

PART I: SECTION E: REVISION INFORMATION

Has the Claimant undergone a revision surgery or surgeries to remove the Wright Profemur Hip Implant System(s)?

○ Yes ○ No

If you checked "No," you are not an eligible Claimant under this settlement.

Location of Revision: ○ Right ○ Left ○ Bilateral

Implant Revision Date (**Right**): M M / D D / Y Y Y Y

Name of Hospital

Surgeon

Implant Revision Date (**Left**): M M / D D / Y Y Y Y

Name of Hospital

Surgeon

Identification stickers and operative report(s) for your Wright Profemur Hip Implant System(s), establishing the implant surgery and subsequent revision surgery, must be submitted with this Claim Form. See Compensation Protocol.

Have you had more than one revision surgery due to fracture of the Wright Profemur Hip Implant System? If so, please describe the circumstances of your further revision surgery:

If the Claimant required a second revision, you must submit hospital records (including revision operative reports) relating to that surgery.

PART I: SECTION F: POST-REVISION COMPLICATIONS

Did the Claimant's revision surgery or surgeries cause any of the following? If so, state the date on which the complication occurred.

○ Stroke M M / D D / Y Y Y Y

○ Blood Clot M M / D D / Y Y Y Y

○ Infection M M / D D / Y Y Y Y

○ Permanent nerve damage M M / D D / Y Y Y Y

If you claimed above that the Claimant experienced a stroke, blood clot, infection, and/or permanent nerve damage, you must submit a completed Physician's Declaration with this form.

PART I: SECTION G: DECLARATION

I solemnly declare that:

The Claimant was implanted with a Wright Profemur Hip Implant System after February 2001 and has suffered a fracture of the Wright Profemur Hip Implant System(s) on or before August 5, 2020, requiring a revision surgery.

The Claimant wishes to make a claim for compensation in this class action.

Attached are copies of the Claimant's implant and revision operative reports and documentation identifying the catalogue and lot numbers of the Claimant's Wright Profemur Hip Implant System(s).

If I am not submitting the Claimant's Wright Profemur Hip Implant System(s) peel-and-stick labels as product identification, it is because the hospital at which the Claimant's implant surgery occurred could not provide me with the labels because they are not in the Claimant's hospital medical records.

If I am not submitting a photograph of the Claimant's Wright Profemur Hip Implant System(s) in lieu of the Claimant's Wright Profemur Hip Implant System(s) peel and stick labels, I cannot submit a photograph because the Claimant's Wright Profemur Hip Implant System(s) is not within the Claimant's or my possession, custody, or control.

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 Claimant or Representative: _____

Dated (mm/dd/yyyy): _____

Print Name: _____

Please note: All pages of this Declaration and supporting documents must be submitted to the Claims Administrator on or before the Claims Deadline of October 8, 2020, together with any other required documentation as outlined in the Compensation Protocol.

II. PHYSICIAN DECLARATION FORM

This Physician Declaration Form must be completed if the Claimant is claiming that he/she experienced a Complication, i.e., stroke, blood clot, infection, and/or permanent nerve damage due to revision surgery.

In completing this Form, you may consider the patient's medical records, charts, reports, diagnostic films, medical history, or other sources of information that physicians regularly and routinely rely upon in their practice. By signing this Form, you certify that all opinions set forth below are offered to a reasonable degree of medical certainty.

PART II: 1. PHYSICIAN BACKGROUND

First Name | M.I. | Last Name

Office Address

City

Province | Postal Code

Area Code — Phone Number — | Area Code — Fax Number —

Check whether you are a/an:

- ○ Orthopedic surgeon
- ○ Cardiologist
- ○ Neurologist
- ○ Cardiothoracic surgeon
- ○ Neurosurgeon
- ○ Other _____

College of Physicians and Surgeons Registration Number:

PART II: 2. PATIENT INFORMATION

State the name and birth date of the patient for whom you are providing the information contained in this Physician Declaration Form.

First Name | M.I. | Last Name

MM / DD / YYYY
Birth Date

Are you one of the patient's treating physicians?

○ Yes ○ No

If "Yes," state your role in the patient's medical care and treatment relative to his/her Wright Profemur Hip Implant System(s):

_____

_____

_____

PART II: 3. IMPLANT INFORMATION

State the reference and catalog numbers that correspond to the patient's Wright Profemur Hip Implant System(s):

Date of Implantation (**Right**): M M / D D / Y Y Y Y

Implant Reference/Catalogue Numbers (if available)

Implant Lot Number (if available)

Date of Implantation (**Left**): M M / D D / Y Y Y Y

Implant Reference/Catalogue Numbers (if available)

Implant Lot Number (if available)

PART II: 4. REVISION SURGERY

Was the patient diagnosed as requiring a revision surgery to replace the Wright Profemur Hip Implant System(s) due to fracture of the implant:

○ Yes ○ No

Date of the diagnosis: M M / D D / Y Y Y Y

Date on which the revision surgery occurred: M M / D D / Y Y Y Y

Describe all reason(s) a revision surgery for the Wright Profemur Hip Implant System(s) was diagnosed:

PART II: 5. COMPLICATIONS RESULTING FROM REVISION SURGERY

○ Check here if the patient sustained any of the following complications during or after his/her revision surgery, and please state the date on which the complication(s) occurred:

(a) Stroke that occurred within 72 hours after a revision surgery to remove a Wright Profemur Hip Implant System as a result of revision surgery	MM / DD / YYYY
(b) Blood clot that occurred within 72 hours after a revision surgery to remove a Wright Profemur Hip Implant System as a result of revision surgery	MM / DD / YYYY
(c) Infection in the revised hip that was diagnosed within 30 days after a revision surgery to remove a Wright Profemur Hip Implant System	MM / DD / YYYY
(d) Permanent nerve damage resulting from a revision surgery to remove a Wright Profemur Hip Implant System	MM / DD / YYYY

Please attach medical records to this form that confirm that the Complication(s) noted above occurred. Such medical records may include, but are not limited to, operative reports, pathology reports, office records, and/or discharge summaries.

PART II: 6. DECLARATION

I affirm that the foregoing representations are true and correct.

Signature of Physician: _____ Dated (mm/dd/yyyy): _____

Print Name: _____

III. COMPENSATION PROTOCOL

Allocation of Settlement

The Settlement Payment will be allocated among eligible Claimants on the basis of a points system, described on page 11.

PART III: A. ELIGIBILITY

Claimant Eligibility

To be eligible to receive a payment under the Settlement Agreement, a Claimant must:

i. Be, or if acting in a representative capacity, be representing the interest of, a Canadian resident;

ii. Demonstrate, by providing a Claim Form and supporting documentation, that the Claimant received a Wright Profemur Hip Implant System after February 2001; and

iii. Demonstrate that the Claimant's Wright Profemur Hip Implant System fractured on or before the Effective Date, requiring revision surgery.

The compensation that you are eligible to receive will be determined based on your status on August 5, 2020. You are required to submit your completed Claim Form, Product Identification and, if you are claiming a Complication, the completed Physician Declaration Form and supporting documentation, on or before October 8, 2020. This is referred to as the "Claims Deadline."

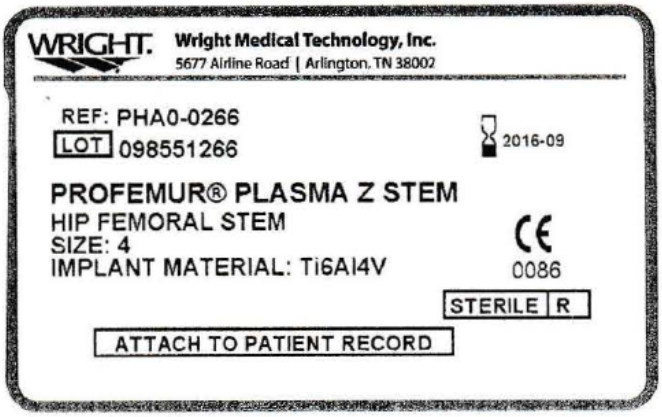
The estate of Ken Taylor, former Representative Plaintiff (deceased as of November 5, 2018), is eligible for compensation under the Settlement Agreement, as an exception to the eligibility requirement that a Class Member be living. Mr. Taylor was Representative Plaintiff from 2011 until 2019.

How is eligibility determined?

In order to participate, you must provide the Wright Profemur Hip Implant System product identification that confirms the reference number (sometimes referred to as "catalogue number") and lot number of the Wright Profemur Hip Implant System device that was implanted ("Product Identification"), in addition to other documents required by the Settlement Agreement. Product Identification confirms that you were implanted with a Wright Profemur Hip Implant System. Product Identification can be found on the peel-and-stick label (the "Label") from the Wright Profemur Hip Implant System that should be affixed to the medical record from your implant surgery (sometimes called the implant operative report). You can obtain your implant surgery medical record from the hospital where your implant surgery occurred or from your physician.

To be eligible under the settlement, the reference/catalogue number on the Label must be one of the following:

The image below is an *example* of Product Identification. Please note that not all product labels are identical to the example provided below, but they are all similar to it. This example is provided to help you identify the location of the reference and lot numbers of your device so that you can confirm that you are eligible under the settlement.



If, and only if, you are unable to obtain the Label because the implant surgery hospital could not locate it in your hospital medical records, then you may provide the following to prove that you received a Wright Profemur Hip Implant System:

a. If the Wright Profemur Hip Implant System has been explanted from your body and it still exists, you must provide (1) a color photograph of the Wright Profemur Hip Implant System that shows the identification numbers on the edge of the Wright Profemur Hip Implant System, and (2) a Physician Declaration confirming that you were implanted with a Wright Profemur Hip Implant System and the date of the implantation;

   OR

b. If you cannot obtain a photograph because your Wright Profemur Hip Implant System is not within your possession, custody, or control, you must provide (1) a copy of your implant surgery operative report from the hospital where you were implanted, in which your surgeon confirms that you were implanted with a Wright Profemur Hip Implant System, and (2) a Physician Declaration confirming that you were implanted with a Wright Profemur Hip Implant System and the date of implantation.

Important Note: Failure to provide Product Identification in the manner stated above by the Claims Deadline October 8, 2020 will render you ineligible to recover under this Settlement Agreement. You will also be ineligible to recover under this Settlement Agreement if your Wright Profemur Hip Implant System has not fractured.

Can the Claims Deadline be extended for any reason?

No, the Claims Deadline is an absolute deadline for which there are no exceptions.

PART III: B. POINTS ALLOCATION & DEFINITION OF COMPLICATIONS

Complication Definitions

The following are Complications:

(1) "Blood Clot" means a diagnosis made within 72 hours of a Revision Surgery of pulmonary embolism or deep vein thrombosis that resulted from a Revision Surgery.

(2) "Permanent Nerve Damage" means nerve damage resulting from a Revision Surgery that has been declared permanent by the medical professional who signed the Physician's Declaration.

(3) "Infection" means any infection in the revised hip that is diagnosed within 30 days after a Revision Surgery and determined to have been caused by the Revision Surgery.

(4) "Stroke" means a cerebrovascular incident or insult occurring within 72 hours of a Revision Surgery.

Corresponding Points Allocation

The points allocated to Claimants are as follows:

BASE POINTS		
Event	**Years Implanted Before Fracture (From Date of Implant to Date of Fracture)**	**Points**
1st Fracture & 1st Revision Surgery	0-2	110
	2-4	100
	4-6	90
	6+	75
2nd Fracture & 2nd Revision Surgery	0-2	90
	2-4	80
	4-6	70
	6+	55

ADDITIONAL POINTS FOR COMPLICATIONS	
Event	**Points**
Blood Clot	10
Infection	10
Permanent Nerve Damage	20
Stroke	40

The points above are cumulative, but in no event shall more than 40 points be awarded to a Claimant for Complications. Thus, regardless of the number of Complications a Claimant has, the Claimant can only be awarded 40 points total for all Complications.

PART III: C. CLAIMANT NOTIFICATION AND CLAIM APPEALS

The Claims Administrator shall notify each Claimant by way of a letter as to the approval or rejection of his or her claim and the points awarded to the Claimant.

Appeals

Claimant will be granted a 30-day period from the date of mailing to appeal the rejection and/or classification of their claims. Appeals will be reviewed and assessed by a referee, to be jointly approved by the parties. Appeals will be made in writing to such referee, supported only by the documentation provided to the Claims Administrator. The appeal shall be conducted entirely in writing. The Claims Administrator shall consider the appeal and render a decision within 30 days following receipt of the appeal material from the Claimant. Following the outcome on appeal there shall be no right of further appeal or review.

PART III: D. CLAIMS PROCESSING GUIDELINES

If, during claims processing, the Claims Administrator finds that technical deficiencies exist in a Claimant's Claim Form or supporting documentation, the Claims Administrator shall notify the Claimant, by way of letter sent through first class regular mail, of the technical deficiencies and shall allow the Claimant 40 days from the date of mailing to correct the deficiencies. If the deficiencies are not corrected within the 40-day period, the Claims Administrator shall reject the claim and the Claimant shall have no further opportunity to correct the deficiencies. "Technical deficiencies" shall not include missing the Claim Deadline or failure to provide sufficient evidence to support the Claimant's claim. In the event that a Claimant has requested but not yet received the required supporting documentation, the Claimant must submit true copies of the records requests that were made and this will be deemed a "technical deficiency."

PART III: E. REPORTING OBLIGATIONS OF CLAIMS ADMINISTRATOR

Within thirty (30) business days after the Claim Deadline, the Claims Administrator shall provide a written report to Class Counsel and to the Defendants providing the total number of Approved Claimants who meet the criteria for payment under the Settlement and the amount awarded to each Claimant ("Claims Report").