DERMALIVE CLASS ACTION SETTLEMENT

CLAIM FORM

TO BE RETURNED BY REGULAR MAIL NO LATER THAN MAY 20, 2015

Please fill out this claim form in order to make a claim.

Instructions

1. **DEADLINE:** To be eligible to receive compensation, your completed **Claim Form, Physician Form, and supporting documents (the "Claim Package")** must be posted by mail or received by the Claims Administrator no later than **May 20, 2015 at 5:00 p.m.** (EST). If the completed Claim Package is not posted by mail or received by the Claims Administrator on or before 5 p.m. (EST), you will lose your right, if any, to receive compensation.

2. **Complete, Correct and Honest Answers.** All applicable questions in this Claim Form must be answered honestly, completely and accurately. If you run out of space, please use and submit additional numbered sheets. The submission of incorrect or incomplete information may delay the processing of your claim, or may lead to the rejection of your claim. The deliberate submission of false or misleading information will result in your being ineligible to participate in the class action Settlement and may result in the imposition of criminal sanctions.

3. **Sign the Claim Form** in the presence of an adult witness at the bottom of page 3.

4. **Keep a copy s**o that you can document the submission of your completed Claim Package. It is recommended that you keep a copy for your records, as well as proof of delivery to the Claims Administrator.

5. **Additional information may be requested**. If the Claims Administrator determines that it needs additional information from you in order to properly assess your claim, it may request additional information.

6. **Submit this Claim Form and all attachments no later than May 20, 2015 to:**

Dermalive Class Action Claims Administrator
P.O. Box 20187 – 390 Rideau Street
Ottawa, ON K1N 9P4
Tel.: 1-866-262-0006
Fax: 1-613-562-0321
Email: info@dermaliveclaim.ca (Claim Form must be attached in PDF format)

SECTION A – CLAIMANT INFORMATION			
First Name:	**Last Name:**		**Middle Name:**
Residence Street Address:		**Unit No.:**	**City:**
Postal Code:	**Province:**	**Email:**	
Home Phone: ( )	**Cell Phone:** ( )	**Work Phone:** ( )	**Date of Birth:** ___ / ___ / _____ DD MM YYYY

SECTION B – LEGAL REPRESENTATIVE

Complete this section ONLY if a lawyer is representing you. All correspondence will be sent to your lawyer. If you receive compensation under the settlement, your cheque will be made payable to your lawyer's law firm "in trust" and sent directly to your lawyer. If you change lawyers or cease to retain your lawyer you must notify BOTH your former lawyer AND the Claims Administrator in writing.

Name of Law Firm:		
Lawyer Last Name:	**Lawyer First Name:**	
Address:		
City:	**Province:**	**Postal Code:**
Telephone:	**Fax:**	**Email:**

SECTION C – PERSONAL REPRESENTATIVE

Complete this section ONLY if you are a personal representative submitting a claim on behalf of a Class Member who requires assistance to manage with his/her financial matters, or a Class Member who is deceased. Attach a copy of the Court Order or other official document(s) (e.g. representation agreement, power of attorney, etc.) demonstrating your right to act on behalf of the Class Member and check the box below describing the person you represent.

☐ An adult who requires assistance with his/her financial matters

☐ The estate of a deceased person Date of Death:___/ ___/ _____
DD/ MM/ YYYY

Last Name:	**First Name:**	
Address:		
City:	**Province:**	**Postal Code:**
Home Telephone:	**Work Telephone:**	**Email:**

SECTION D – CONTACT AUTHORIZATION

Complete this section ONLY if you want the Claims Administrator to speak with someone other than you about your claim (e.g. lawyer, spouse, son or daughter, friend, etc.).

I authorize the Claims Administrator to speak with _____ my_____ on my behalf. (Name) (Relationship to Claimant)

SECTION E – DERMALIVE INJECTION DATES	
*Enclose proof of Dermalive injection (i.e. medical records, receipt(s), or note from physician)	
Dermalive Injection #1 ____/ ____/ ______ DD / MM / YYYY	**Dermalive Injection #2** ____/ ____/ ______ DD / MM / YYYY
Dermalive Injection #3 ____/ ____/ ______ DD / MM / YYYY	**Dermalive Injection #4** ____/ ____/ ______ DD / MM / YYYY

SECTION F –TREATMENT

1. Did you receive surgery, injection, laser, or other treatment(s) for the areas adversely affected by reaction to Dermalive? ☐ *Yes* ☐ *No*

*Enclose medical records for all treating physicians or other evidence of treatments

*Enclose receipts for adverse reaction treatment costs paid by Claimant

Treatment Date	Treatment Description	Amount Paid
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________
____ / ____ / ______ DD / MM / YYYY	☐ *Surgery* ☐ *Laser* ☐ *Injection* ☐ *Other (describe):*	$ ________

SECTION G – DECLARATION & SIGNATURE

DECLARATION ABOUT DERMALIVE INJECTIONS, INJURY, TREATMENT AND DAMAGES.

- I confirm that I received Dermalive injections
- I confirm that the areas adversely affected by reaction to Dermalive on my face are located in the same areas where I had Dermalive injections
- I confirm that all of the information provided in this Claim Form is true, whether made by me or on my behalf. Where someone has helped me with this Claim Form that person has read to me everything they wrote if necessary to allow me to understand the content of this completed Claim Form and any attachments to it, and I confirm that information is true. I know that signing this Claim Form has the same effect as if I had stated the information contained in the Claim Form under oath (or affirmation) in court.

_____

CLAIMANT SIGNATURE

_____

WITNESS SIGNATURE

(Witness must know claimant and watch claimant sign. Witness does not need to read the Claim Form. Witness must be over 19 years of age.)

_____

Print Name of Witness

_____

Date signed (DD/MM/YYYY)