Avandia Class Action
RicePoint Administration
PO Box 4454, Toronto Station A
25 The Esplanade
Toronto, ON M5W 4B1

GXQ

Albert Carl Sweetland and Barbara Fontaine v. GlaxoSmithKline Inc. and GlaxoSmithKline LLC

SUPREME COURT OF NOVA SCOTIA

File Hfx. No. 315567

Must Be Postmarked No Later Than July 15, 2020

Claim Form

PRIMARY CLASS MEMBER CLAIMANT INFORMATION

First Name | M.I. | Last Name

Primary Address

Primary Address Continued

City

Province | Postal Code | Country Name/Abbreviation

CLAIM FORM PACKAGE
Private & Confidential

This Claim Form Package contains:

- Agreement and Instructions
- Claim Form
- Privacy Statement
- Risk Factor Declaration

AGREEMENT AND INSTRUCTIONS

A. This is a "Claim Form" referred to in the Avandia Class Action National Amended Settlement Agreement dated June 3, 2019 (the "Settlement Agreement"), for the resolution of all claims for damages against, and all liabilities of GlaxoSmithKline INC. and GlaxoSmithKline LLC by all persons in Canada, including their estates, who were prescribed and ingested Avandia (the "Primary Class"); and the spouses (including common-law spouses and same-sex spouses), children, grandchildren, parents, grandparents and siblings of deceased members of the Primary Class (the "Family Class"). Capitalized terms used but not defined in this Claim Form shall have the respective meanings assigned to such terms in the Settlement Agreement. In the event of any conflict between any term of this Claim Form and the terms of the Settlement Agreement, the terms of the Settlement Agreement shall prevail.

B. This Claim Form is to be used for submitting an alleged personal injury claim by:
   (a) All persons in Canada, including their estates who were prescribed and ingested Avandia (the "Primary Class").

The spouses (including common-law spouses and same-sex spouses), children, grandchildren, parents, grandparents and siblings of deceased members of the Primary Class (the "Family Class'') are not eligible for compensation under the Settlement Agreement.

C. ON OR BEFORE JULY 15, 2020 YOU MUST SERVE each of the following:
   (1) the completed and dated Claim Form;
   (2) all supporting documentation;
   (3) the completed Risk Factor Declaration Form (Optional)

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

All of these materials are to be sent to the Claims Administrator at the following address:

Avandia Class Action
RicePoint Administration
PO Box 4454, Toronto Station A
25 The Esplanade
Toronto, ON M5W 4B1

D. To the extent that the person submitting this Claim Form on behalf of a Primary Class Member Claimant is representing a minor, an incapable person, a person under a disability or the estate of a deceased person, such representative must represent and warrant that he or she is duly authorized as the proper representative to submit the claim and provide proof of same.

E. Notice: The submission of a Claim Form and/or any other documentation to the Claims Administrator, the Defense Parties, Class Counsel or anyone else does not mean that the Primary Class Member Claimant will receive any payment under the Settlement Agreement. There are strict eligibility criteria which have been approved by the Courts that a Primary Class Member Claimant must first satisfy in order to be entitled to payment under the Settlement Agreement.

F. All settlement documents and information can be found on the settlement website: http://www.avandiaclassaction.ca/

The Claims Administrator can be reached for clarification and/or questions at:
Toll Free - 1-866-458-2144
Email inquiries – Info@AvandiaClassAction.com

CLAIM FORM

THIS CLAIM FORM SHOULD BE COMPLETED BY OR ON BEHALF OF THE CLAIMANT

DEADLINE TO SUBMIT ALL CLAIM DOCUMENTATION: JULY 15, 2020

UNLESS NOTED OTHERWISE, YOU MUST ANSWER ALL OF THE FOLLOWING QUESTIONS ON THIS FORM AND, IF NECESSARY, ATTACH ADDITIONAL SHEETS

ALL SUPPORTING DOCUMENTATION AND MEDICAL RECORDS MUST BE SENT TO PROVE CLAIM ELIGIBILITY

CATEGORY OF CLAIM:

Please check off below the type(s) of event(s) you claim resulted from the use of Avandia. Compensation is available for Class Members who used Avandia for at least thirty continuous days commencing before December 2010 and who suffered one of the following injuries within no more than one year of such use: myocardial infarction (heart attack), congestive heart failure, coronary artery bypass graft (CABG) surgery, and percutaneous coronary intervention with stent placement. Other eligibility considerations described in the Settlement Agreement will affect how much compensation you receive.

FILL IN THE APPLICABLE CIRCLE(S)

Contemporaneous medical records must demonstrate one of the below cardiac events. Please indicate which cardiac event:

◯	Final diagnosis of Myocardial Infarction (MI) (which includes a final diagnosis in medical records generated in the course of medical care that interpret clinical signs and/or diagnostic tests as establishing the occurrence of an MI at or about such time or, alternatively for purposes of this criterion, death from a cardiac event in the absence of any other cause of death).
◯	Underwent Coronary Artery Bypass Graft (CABG),
◯	Underwent Percutaneous Coronary Intervention with Stent Placement
◯	Final diagnosis of initial onset or exacerbation of Congestive Heart Failure (CHF) (which includes a final diagnosis of initial onset or exacerbation of CHF in medical records generated in the course of medical care that interprets clinical signs and/or diagnostic tests as establishing the initial onset or exacerbation of CHF at or about such time).

1. Information about Primary Class Member Claimant:

a. Current name and other names (e.g., maiden names, married names) used by the Primary Class Member Claimant for the cardiac event:

Prefix: ◯ Mr. ◯ Mrs. ◯ Miss ◯ Dr.

First Name

Middle Name

Last Name

Prior Last Name

b. Primary Class Member Claimant's current or last known residence address:

Primary Address

Primary Address Continued

City

Province

Postal Code

Country Name/Abbreviation

Daytime Phone Number

Evening Phone Number

Email Address

c. Primary Class Member Claimant's date of birth: MM / DD / YYYY

d. Primary Class Member Claimant's health card number:

e. Language Preference: ◯ English ◯ French

2. Information about a Legal Representative (e.g. Executor of the Primary Class Member Claimant's Estate) (if applicable)

This Section is to be completed only if this claim is being made by a legal representative on behalf of a Primary Class Member Claimant.

If you are claiming as legal representative of the Primary Class Member Claimant, please provide details about your relationship to the Primary Class Member Claimant (e.g., as the executor for the estate of a Primary Class Member Claimant) and attach copies of the court orders making such appointment, or other authorization or official document(s) demonstrating that you are the duly authorized legal representative of the Primary Class Member Claimant.

Type of legal representative (e.g. executor of estate, guardian)

Prefix: ◯ Mr. ◯ Mrs. ◯ Miss ◯ Dr.

First Name

Middle Name

Last Name

Prior Last Name

Relationship to Primary Class Member Claimant (i.e., spouse (or former spouse) or child)

MM / DD / YYYY
Date of Birth

Primary Address

Primary Address Continued

City

Province

Postal Code

Foreign Country Name/Abbreviation

Daytime Phone Number

Evening Phone Number

Email Address

Language Preference: ◯ English ◯ French

3. Legal Counsel Identification (if applicable)

This Section is to be completed only if a lawyer is representing the Primary Class Member Claimant.

Law Firm Name

Lawyer's Last Name

M.I.

First Name

Primary Address

Primary Address Continued

City

Province

Postal Code

Country Name/Abbreviation

Phone Number

Fax Number

Email Address

Language Preference: ◯ English ◯ French

Note: If you complete Section 3 above, all correspondence will be sent to your lawyer, who must notify the Claims Administrator of any change in mailing address. If you change lawyers, you must notify the Claims Administrator in writing of the new information.

4. Facts Concerning Primary Class Member Claimant's Ingestion of Avandia:

Primary Class Member Claimants ***must demonstrate, from contemporaneous medical or pharmacy records:***

- ***at least 30 days of uninterrupted Avandia usage at the time of, or within one year prior to, the cardiac event; and***
- ***that such Avandia use occurred prior to December 2010, or that an uninterrupted period of such use began prior to December 2010***

a. Date Avandia use started and stopped:

Start Date MM / DD / YYYY to End Date MM / DD / YYYY

b. Frequency of use of Avandia:

◯ Everyday

◯ As needed

c. Was the Primary Class Member Claimant taking Avandia at the time of his/her cardiac event? ◯ Yes ◯ No

d. Was the Primary Class Member Claimant taking Avandia within one year prior to his/her cardiac event? ◯ Yes ◯ No

e. Please indicate the date of the cardiac event:

MM / DD / YYYY

PRIVACY STATEMENT

All personal information provided by or on behalf of the Claimant to the Claims Administrator will be handled in accordance with applicable privacy laws and the Claims Administrator's privacy policies available at www.ricepoint.com. Such information will be used for the purposes of administering the Settlement Agreement, including evaluation by the Claims Administrator, Class Counsel, Defense Counsel, and the Referee jointly approved by the parties, of the Claimant's eligibility for compensation under the Settlement Agreement. Personal information provided by the Claimant will not be disclosed without further express written consent of the Claimant, except to Class Counsel, Defense Counsel, and the Referee jointly approved by the parties; to appropriate persons to the extent necessary to process claims or provide benefits under the Settlement Agreement; as otherwise expressly provided in the Settlement Agreement; pursuant to court order, or as otherwise permitted or required by law; as may be reasonably necessary in order to enforce, or for Class Counsel or Defense Counsel to exercise their respective rights (including appeal rights) under the Settlement Agreement; or to the immediate family members, counsel, accountants and/or financial advisors of the Claimant (each of whom the Claimant shall instruct to maintain and honour the confidentiality of such information).

Claimant Verification Signature

By signing below, you acknowledge and agree to the following:

a) You swear under oath that all information provided in this form is true to the best of your knowledge and belief.

b) You are bound by the full and final release of all your claims against Defendants and other Released Parties as set forth in the Settlement Agreement, which are hereby incorporated by reference herein, and receipt of benefits under the terms of the Settlement Agreement shall be your exclusive remedy against such Defendants and other Released Parties.

Claimant's Signature (or Claimant's Representative) Date (mm/dd/yyyy)

Printed Name of Claimant (or Claimant's Representative) Date (mm/dd/yyyy)

Signature of Claimant's Lawyer (if any) Date (mm/dd/yyyy)

Printed Name of Claimant's Lawyer (if any) Date (mm/dd/yyyy)

RISK FACTOR DECLARATION FORM

I, _____, from the City of _____, in the province of _____,

SOLEMNLY DECLARE:

1. **Prior to suffering my Cardiac Event, I was not diagnosed with any of the following:**
    i. **congestive heart failure (CHF);**
    ii. **myocardial infarction (heart attack);**
    iii. **coronary artery disease (CAD);**
    iv. **high cholesterol and/or prescribed cholesterol lowering medication;**
    v. **high blood pressure and/or prescribed blood pressure lowering medication;**
    vi. **obesity; or**
    vii. **alcohol dependency/alcohol addiction (within two (2) years of my cardiac event)**
2. **I did not smoke cigarettes or cigars within one (1) year of my cardiac event.**
3. **I did not use illegal drugs (including, but not limited to, cocaine, LSD and heroin, but excluding marijuana) within two (2) years of my cardiac event.**
4. **I acknowledge and understand that this Declaration is an official Court document sanctioned by the Court that presides over the Settlement, and submitting this Declaration to the Claims Administrator is equivalent to filing it with a Court.**

Enclosed in support of this Declaration are my medical records required pursuant to the Compensation Protocol which I understand may be reviewed by the Claims Administrator to confirm the contents of this Declaration.

After reviewing the information that has been supplied in this Declaration I declare under penalty of perjury that the information provided in this Declaration and Claim Form is true and correct to the best of my knowledge, information and belief.

I hereby consent to the disclosure of the information contained herein to the extent necessary to process this claim for benefits. I hereby authorize the Claims Administrator to contact me as required in order to administer the claim.

_____ _____
Claimant's Signature (or Claimant's Representative) Dated (mm/dd/yyyyy):

_____
Printed Name of Claimant (or Claimant's Representative)

_____ _____
Signature of Claimant's Lawyer (if any) Dated (mm/dd/yyyyy):

_____
Printed Name of Claimant's Lawyer

_____ _____
Signature of Witness Dated (mm/dd/yyyyy):

_____
Printed Name of Witness