THE MEAT SHOP AT PINE HAVEN/MAMA NITA'S BINALOT ACTION GLOBAL SETTLEMENT
BODILY INJURY CLAIM FORM

Section 1 - Class Member Identification

Class Member First Name _____ Last Name: _____

Address _____ P.O. Box _____

City _____ Province _____

Postal Code _____

Birth Date Year _____ Month _____ Day _____

Provincial Health Care Number _____

Date of Death (if applicable) Year _____ Month _____ Day _____

Please attach the official death certificate

Home Phone _____ Work Phone _____

Section 2 - Representative Claimant Identification

This section is to be completed only if you are submitting a claim as the Representative of a Class Member. You MUST provide proof of your authority to act as the representative of a Class Member.

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

- ☐ **A minor (under 18 years of age)**

  Please enclose: (1) a copy of your authority to act (i.e. long-form birth certificate, baptismal certificate, court order or other proof of guardianship); and (2) a completed Acknowledgement of Responsibility (see Schedule A).

- ☐ **A person under legal disability**

  Please enclose a copy of your authority to act (i.e. power of attorney, etc.)

- ☐ **Deceased**

  Please enclose a copy of your authority to act (i.e. will, court order, etc.)

Representative Claimant First Name _____ **Last Name** _____

Address_____ **P.O. Box** _____

City _____**Province** _____

Postal Code _____ **Phone** _____

Section 3 - Legal Representative Identification

This Section is to be completed ONLY If a lawyer or agent is representing the Claimant. If you complete this section, all correspondence will be sent to your legal representative.

Name of Law Firm or Agency

Lawyer's or Agent's Last Name _____First Name _____

Address _____ P.O. Box _____

City _____ Province _____

Postal Code/Zip Code _____

Phone _____ Fax _____

Section 4 – Injury Source

Type of food causing Illness: _____

Where was the food purchased: _____

When was the food purchased or acquired: _____

Where was the food prepared: _____

When was the food prepared: _____

Where was the food consumed: _____

When was the food consumed: _____

Section 5(A) — Description of Symptoms

I,_____, hereby declare under penalty and perjury that the Class Member consumed Recalled Pork and suffered the following injury or illness as a result:

Please check all symptoms that the Class Member experienced:

- ❑ Diarrhea (watery or bloody). Length of time symptom lasted: _____
- ❑ Moderate to severe stomach cramps or tenderness. Length of time symptom lasted: _____
- ❑ Nausea. Length of time symptom lasted: _____
- ❑ Vomiting. Length of time symptom lasted: _____
- ❑ Bowel incontinence. Length of time symptom lasted: _____
- ❑ Other symptoms. Please specify and length of time symptoms lasted _____

Are any of the symptoms on-going?

_____
_____

Was the class member admitted overnight into a hospital?

- ❑ Yes. Please specify name of hospital and duration of hospitalization:

  Name of Hospital: _____

  Number of Days:_____

- ❑ No

Did the class member experience kidney failure?

- ❑ Yes

  Please describe _____

  _____

  For how many days or months? _____

- ❑ No

Was the class member diagnosed with haemolytic uremic syndrome (HUS)?

- ❑ Yes
- ❑ No

Did the class member die as result of his or her illness?

- ❑ Yes
- ❑ No

Section 5(B) Supporting Medical Documentation

Supporting medical documentation is as follows:

(a) Physician's notes, hospital admission records, or other documents, created by a physician, hospital or other health care professional recording symptoms consistent with *E. Coli* O157 infection.

(b) Physician's notes, hospital admission records, or other documents created by a physician, hospital, or other healthcare professional confirming diagnosis with *E. Coli* O157 infection.

(c) If a class member did not seek any medical attention, verification of the same and identification of any witness to the injuries. Statutory Declaration that the Class Member consumed Recalled Pork and suffered illness or injury as a result (the "Statutory Declaration") and separate affidavit from the third-party witness to verify first-hand observation of the illness and impact on the claimant.

Section 6 -Special Damages

Describe any out of pocket expenses incurred by the class member or parent or direct family member as a result of the class members' illness. **All invoices, receipts and supporting documents MUST be attached to this Claim Form.**

Section 7 – Wage Loss

Employer verification of missed work and income loss MUST be attached to this Claim Form.

Wage Loss Claimed: $_____

Hourly Wage: _____

Number of Days Missed from Work: _____

Name of Employer: _____

Phone Number of Employer: _____

Email Address of Employer: _____

Section 8 — Release of Claims

I verify that I have NOT received compensation through other proceedings or private out-of-class settlements and/or provided a release in respect of the recall.

If you have received compensation or released claims, please provide the details here:

Compensation: $ _____

Details of Claims Released: _____

Section 9 - Claimant Declaration and Authorization

The undersigned hereby consents to the disclosure of the information contained herein to the extent necessary to process this claim for benefits. The undersigned acknowledges and understands that this Claim Form is an official Court document sanctioned by the Court that presides over the Settlement and submitting this Claim Form to the Claims Administrator is equivalent to filing it with a Court.

The undersigned-hereby authorizes the Claims Administrator to contact the Class Member as required in order to administer the claim.

After reviewing the information that has been supplied on this Claim Form, the undersigned declares under penalty of perjury that the information provided in this Claim Form is true and correct to the best of his/her knowledge, information and belief.

Date: _____ _____
Claimant's Signature (or Claimant's Representative)

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

Date: _____ _____
Signature of Claimant's Lawyer (if any)

_____
Printed Name of Claimant's Lawyer

SCHEDULE A - GUARDIAN'S ACKNOWLEDGMENT OF RESPONSIBILITY

(Minors' Property Act (Section 8))

This acknowledgment of responsibility is given by:

Name (name of guardian): _____

Address: _____

1. This acknowledgment of responsibility relates to the minor, _____ (name of minor); who was born on _____ (day, month, year:).

2. I am the minor's guardian because I am:

   - ❑ the minor's mother or father
   - ❑ appointed guardian by the deed or will of the minor's parent, _____(name of parent) who is now deceased
   - ❑ appointed guardian by a court order dated _____ (date of guardianship order).

3. I have the power and responsibility to make day-to-day decisions affecting the minor.

4. I request the Claims Administrator to deliver to me, to hold as trustee for the minor, money payable to the minor pursuant to the Settlement.

5. I will use or expend the money only for the minor's benefit.

6. When the minor reaches the age of 18 years I will account to the minor and transfer the balance of the money remaining at that time to the minor.

Date _____

Guardian's Signature _____

Witness _____