

SCHEDULE C

DAYA CLASS ACTION SETTLEMENT

SHORTFORM CLAIM APPLICATION PACKAGE

**THE FINAL DATE FOR SUBMISSION OF
THE SHORTFORM CLAIM FORM AND THE
REQUIRED SUPPORTING DOCUMENTATION IS
MAY 30, 2008**

CLASS ACTION FILE #04-CV-281230CM

DAYA CLASS ACTION SETTLEMENT SHORTFORM CLAIM APPLICATION PACKAGE

THIS SHORTFORM CLAIM APPLICATION PACKAGE CONTAINS:

- Summary of Settlement Compensation
- Checklist to ensure you complete the appropriate version of the Claim Form
- General Instructions on Completing the Shortform Claim Form and Providing Required Supporting Documentation
- Shortform Claim Form
- Physician's Form

SUMMARY OF SETTLEMENT COMPENSATION

- \$35,000 for any woman who underwent a Tompkins Metroplasty performed by Dr. Daya at Hamilton Health Sciences Corporation in the period January 1, 1990 to March 31, 2004, inclusive, provided she does not opt out of the class action and provided a Claim Form and all required supporting documentation is submitted to the Administrator by the Claims Bar Date (the "eligible Class Member").
- Up to an additional \$20,000 if the Tompkins Metroplasty materially contributed to the eligible Class Member experiencing any of the specific medical complications or interventions listed in Section C of the Shortform Claim Form in the indicated timeframe. The amount of the additional compensation will depend upon the nature and number of medical complications or interventions the eligible Class Member experienced, and the number of valid claims for additional compensation by eligible Class Members.
- \$2,000 to be divided among the following living members of the eligible Class Member's family who were also alive on the date of the Tompkins Metroplasty (the "Family Class Member"):
 - spouse (married or common-law)
 - children
 - parents
 - siblings
 - grandparents
 - grandchildren
- If there is a surplus in settlement funds after payment of the compensation as outlined and payment of all counsel and administration costs, the remaining settlement funds will be divided equally among all eligible Class Members.
- For more detailed information, please refer to the Judgment and the Distribution Plan at www.dayaclassaction.com.

CLAIMS BAR DATE

To claim settlement compensation, a completed Claim Form and the required supporting documentation must be submitted to the Administrator **no later than May 30, 2008, or such later date as fixed by the Court:**

by mail to: The Administrator—Daya Class Action
c/o Sutts, Strosberg LLP
600-251 Goyeau Street
Windsor ON N9A 6V4

or by fax to: The Administrator—Daya Class Action
866.316.5308

Failure to submit a Claim Form and the required supporting documentation by May 30, 2008, or such later date as fixed by the Court, will eliminate all rights to claim/receive compensation under this settlement.

PRIVACY STATEMENT

Personal information is collected and retained by the Administrator pursuant to the *Personal Information Protection and Electronics Documents Act*, S.C. 2000, c.5:

- for the purpose of operating and administering this settlement
- to consider and evaluate eligibility under this settlement
- is strictly private and confidential and will not be disclosed, except as provided for in this settlement without the express written consent of the person who submitted the claim

THE CHECKLIST TO ENSURE YOU COMPLETE THE APPROPRIATE VERSION OF THE CLAIM FORM

Answer these questions about the person who had the Tompkins Metroplasty (the "Class Member");

- Is the Class Member alive? Yes No
- Is the Class Member a mentally capable person? Yes No
- Is every child, sibling and/or grandchild of the Class Member who was alive on the date of the Tompkins Metroplasty currently over the age of 18? Yes No
- Is every spouse, child, parent, sibling, grandparent and grandchild of the Class Member who was alive on the date of the Tompkins Metroplasty currently a mentally capable person? Yes No

If you answered "Yes" to all of the above questions, complete the Shortform Claim Form contained in this package.

If you answered "No" to any of the questions above, do not complete the Shortform Claim Form. Instead, complete a Longform Claim Form. You may print the Longform Claim Application Package off the Administrator's website www.dayaclassaction.com or contact the Administrator as follows to have a Longform Claim Application Package mailed to you.

by mail to: The Administrator—Daya Class Action c/o Sutts, Strosberg LLP 600-251 Goyeau Street Windsor ON N9A 6V4	or by fax to: The Administrator—Daya Class Action 866.316.5308
	or by email to: administrator@dayaclassaction.com
	or by telephone to: 800.229.5323 extension 8291

GENERAL INSTRUCTIONS ON COMPLETING THE SHORTFORM CLAIM FORM AND PROVIDING THE REQUIRED SUPPORTING DOCUMENTATION

The person who underwent the Tompkins Metroplasty (the "Class Member") must:

- Print your name clearly at the top of each page of the Shortform Claim Form.
- Complete Section A of the Shortform Claim Form.
- Complete Section B of the Shortform Claim Form listing certain of your family members ("Family Class Members") and designate a Family Class Member to receive the Family Class Member payment in trust for all of the Family Class Members.
- Have the Undertaking at Section B of the Shortform Claim Form signed by the designated Family Class Member if all Family Class Members agree on how the \$2,000 Family Class Member payment will be divided. If there is no agreement, the Arbitrator will decide how to divide the payment among the Family Class Members.
- Complete Section C of the Shortform Claim Form only if you are making a claim for additional compensation because the Tompkins Metroplasty materially contributed to your experiencing certain medical complications or interventions within the indicated timeframes.
- Indicate in Section D that you are submitting the required supporting documentation for those Sections you have completed on the Shortform Claim Form (see the General Instruction on Required Supporting Documentation below). Sign the Declaration at Section D of the Shortform Claim Form certifying that the information contained in the Shortform Claim Form is true, accurate and complete.
- If you are making a claim for additional compensation under Section C of the Shortform Claim Form, print your name clearly at the top of each page of the Physician's Form and complete Section A of the Physician's Form, only. Have your physician complete all of the remaining Sections of the Physician's Form.
- Submit the Shortform Claim Form, the required supporting documentation and the Physician's Form, if applicable, to the Administrator by May 30, 2008.

REQUIRED SUPPORTING DOCUMENTATION

- The required supporting documentation is indicated in the various Sections of the Shortform Claim Form.
- A photocopy of a Birth Certificate, Health Card, hospital or medical records, or other required supporting documentation is acceptable so long as it is legible.
- If the Class Member's hospital records from Hamilton Health Sciences Corporation are required, you may arrange to obtain them for no charge by calling the Hospital at 866.492.2472.
- Retain a copy of the completed Shortform Claim Form, Physician's Form, if applicable, and all required supporting documentation for your records.

If you require assistance regarding completion of the Shortform Claim Form or have questions concerning the claim, you may seek assistance from the Administrator by email to administrator@dayaclassaction.com or by calling 800.229.5323 extension 8291, or you may retain legal counsel at your own expense.

DAYA CLASS ACTION SETTLEMENT SHORTFORM CLAIM FORM

SECTION A—IDENTIFICATION OF THE CLASS MEMBER

Complete this section about the person who underwent the Tompkins Metroplasty (the "Class Member").

Submit the Class Member's Birth Certificate, Health Card and only that portion of the Class Member's hospital record from Hamilton Health Sciences Corporation that evidences a Tompkins Metroplasty was performed by Dr. Daya and the date of the procedure with this Shortform Claim Form.

Last Name _____

File # _____

For Office Use Only

First Name & Initial _____

Other surnames the Class Member has used from the time of the Tompkins Metroplasty to present _____

Current Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Birth Date: Year _____ Month _____ Day _____

Health Card # _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____

Email Address _____

What was the date of the Tompkins Metroplasty Dr. Daya performed on the Class Member?

_____ (Day) _____ (Month) _____ (Year)

Complete the section below only if the Class Member is represented by legal counsel.

If a Class Member is represented by legal counsel all further communication will be with her legal counsel.

SECTION A – IDENTIFICATION OF THE CLASS MEMBER'S LEGAL COUNSEL, IF APPLICABLE

Name of Law Firm _____

Last Name _____ First Name _____

Address _____

City _____ Province _____ Postal Code _____

Work Phone _____ - _____ - _____ Fax _____ - _____ - _____

Email Address _____

Legal counsel are advised to review the provisions in the Distribution Plan regarding Counsel Fees and Directions to Pay Counsel Fees.

SECTION B - IDENTIFICATION OF FAMILY CLASS MEMBERS

Complete this section about all Family Class Members of the Class Member.

If you need more room to list all Family Class Members, attach a separate sheet.

Note:

You must use the Longform Claim Form if any Family Class Member is under the age of 18 or is a mentally incapable person. See the Checklist on page 2 of this Shortform Claim Application Package.

1. At the time the Tompkins Metroplasty was performed, did the Class Member have any of the following Family Class Members who are still living:
- a spouse (married, or cohabited continuously for not less than 3 years, or in a relationship of some permanence and the parents of a child) Yes No
 - child Yes No
 - parent Yes No
 - sibling Yes No
 - grandparent Yes No
 - grandchild? Yes No

If you answered "Yes" to any part of question 1, complete the information below. If you answered "No" to all of the categories of Family Class Members in question 1, go to Section C of the Shortform Claim Form.

2. Identify all Family Class Members alive at the time of the Tompkins Metroplasty who are currently alive and fit any of the categories in question 1 listed above.

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

Name _____ DOB _____ Relationship to you _____

3. Have all Family Class Members agreed on how to divide the Family Class Member payment among themselves? Yes No

SECTION B – DESIGNATION OF FAMILY CLASS MEMBER

Identify the Family Class Member designated to receive the \$2,000 Family Class Member payment in trust for all Family Class Members.

Name of the Family Class Member being designated _____

Current Address _____

City _____ Province _____ Postal Code _____

Home Phone _____ - _____ - _____ Work Phone _____ - _____ - _____

Email Address _____

Relationship to Class Member: _____

SECTION B - UNDERTAKING TO THE COURT BY THE DESIGNATED FAMILY CLASS MEMBER

Have the person designated to receive the Family Class Member payment complete this Undertaking only if all Family Class Members agree on how to divide the Family Class Member payment.

NOTICE: Any person who submits an Undertaking to the Court containing inaccurate and/or false information to obtain undue benefits under this settlement may be subject to criminal and/or civil action.

I, _____, am the Family Class Member designated
(Name)

to receive the Family Class Member payment on behalf of all Family Class Members identified in Section B of this Claim Form.

I hereby certify that:

- a division of the Family Class Member payment has been agreed to by all of the Family Class Members;
- I will receive the monies in trust for all of the said Family Class Members; and
- I will pay the monies out to the said Family Class Members in the amounts we have agreed.

Signed at _____ this _____ of _____,
(City) (Day) (Month) (Year)

Witness

Signature

SECTION C- APPLICATION FOR ADDITIONAL COMPENSATION FOR SPECIFIC MEDICAL COMPLICATIONS/INTERVENTIONS

Complete this section only if the Tompkins Metroplasty materially contributed to the Class Member experiencing one or more of the medical complications/interventions listed below. A physician's opinion on causation is required to support the claim.

Indicate all of the listed complications/interventions which apply.

- 1. Did the Class Member experience a wound dehiscence (the wound from the Tompkins Metroplasty opened or split) within three months of the Tompkins Metroplasty? Yes No
- 2. Did the Class Member undergo a D & C (dilation and curettage) for any reason other than an early pregnancy loss within six months of the Tompkins Metroplasty? Yes No
- 3. Did the Class Member undergo a D & C (dilation and curettage) as a result of an early pregnancy loss within twelve months of the Tompkins Metroplasty? Yes No
- 4. Did the Class Member undergo an umbilical hernia repair anytime after the Tompkins Metroplasty? Yes No
- 5. Did the Class Member undergo a hysterectomy anytime after the Tompkins Metroplasty? Yes No
- 6. Did the Class Member undergo a salpingectomy (removal of fallopian tube) anytime after the Tompkins Metroplasty? Yes No
- 7. Did the Class Member undergo a laparoscopy to treat an ectopic pregnancy anytime after the Tompkins Metroplasty? Yes No
- 8. Did the Class Member deliver a stillborn child by caesarian section as a result of premature labour anytime after the Tompkins Metroplasty? Yes No
- 9. Did the Class Member undergo a surgical repair at any time as a result of the Tompkins Metroplasty? Yes No

If you answered "Yes" to one or more of these questions, describe what occurred:

If you answered "Yes" to any of the questions above, you must submit the completed Physician's Form and the supporting hospital or medical records. Include only the portions of the Class Member's hospital or medical records that evidence the medical complication/intervention, the date it occurred and its cause.

SECTION C – APPLICATION FOR ADDITIONAL COMPENSATION FOR SECOND TOMPKINS METROPLASTY

Complete this section only if the Class Member underwent a second Tompkins Metroplasty.

10. Did the Class Member undergo a second Tompkins Metroplasty performed by Dr. Daya in the period January 1, 1990 to March 31, 2004, inclusive? Yes No

11. What was the date of the second Tompkins Metroplasty Dr. Daya performed on the Class Member? Yes No

_____ (Day) _____ (Month) _____ (Year)

If you completed this section, submit only that portion of the Hamilton Health Sciences Corporation hospital record that evidences a second Tompkins Metroplasty was performed by Dr. Daya and the date of the procedure. A completed Physician's Form is not required to confirm a second Tompkins Metroplasty.

SECTION D – REQUIRED SUPPORTING DOCUMENTATION

With this Shortform Claim Form I am submitting the following required supporting documentation:

For all persons completing Section A – IDENTIFICATION OF THE CLASS MEMBER.

- 1. Birth Certificate of Class Member. Yes No
- 2. Health Card of Class Member. Yes No
- 3. The Class Member's hospital records from Hamilton Health Sciences Corporation evidencing the Tompkins Metroplasty and the date it occurred. Yes No

For persons who answered "Yes" to Section C – Questions 1 to 9 only.

- 4. Completed Physician's Form. Yes No
- 5. The Class Member's hospital or medical records evidencing each medical complication/intervention experienced, the date it occurred and its cause. Yes No

For persons who answered "Yes" to Section C - Question 10 only.

- 6. The Class Member's hospital records from Hamilton Health Sciences Corporation evidencing a second Tompkins Metroplasty and the date it occurred. Yes No

SECTION D - DECLARATION OF CLASS MEMBER

NOTICE: Any person who submits a Shortform Claim Form to the Administrator containing inaccurate and/or false information to obtain undue benefits under this settlement may be subject to criminal and/or civil action.

I hereby certify that:

- the information I have provided in this Shortform Claim Form is, to the best of my knowledge, information and belief, true, accurate and complete; and
- I have listed all the Family Class Members alive on the date of the Tompkins Metroplasty who are currently alive on this Shortform Claim Form.

Signed at _____ this _____ of _____, _____
(City) (Day) (Month) (Year)

Witness

Signature of Class Member

PHYSICIAN'S FORM

SECTION A - IDENTIFICATION OF PATIENT

Complete this section about the person who underwent the Tompkins Metroplasty (the "Patient").

Last Name _____ First Name & Initial _____

Health Card # _____

Date the Tompkins Metroplasty was performed: _____ (Day) _____ (Month) _____ (Year)

SECTION B - IDENTIFICATION OF PHYSICIAN

Last Name _____ First Name & Initial _____

Address _____

City _____ Province _____ Postal Code _____

Work Phone _____ - _____ - _____ Fax _____ - _____ - _____

Email Address _____ Specialty _____

SECTION C - COMPLICATIONS/INTERVENTIONS EXPERIENCED FOLLOWING A TOMPKINS METROPLASTY

Indicate all of the listed medical complications/interventions experienced by the Patient which were materially contributed to by the Tompkins Metroplasty.

Did the Tompkins Metroplasty **materially contribute** to the Patient experiencing one or more of the following medical complication/interventions in the indicated timeframe:

- wound dehiscence within three months of the Tompkins Metroplasty Yes No
- a D & C for any condition other than an early pregnancy loss within six months of the Tompkins Metroplasty Yes No
- a D & C as a result of an early pregnancy loss within twelve months of the Tompkins Metroplasty Yes No
- an umbilical hernia repair anytime after the Tompkins Metroplasty Yes No
- a hysterectomy anytime after the Tompkins Metroplasty Yes No
- a salpingectomy anytime after the Tompkins Metroplasty Yes No
- a laparoscopy to treat an ectopic pregnancy anytime after the Tompkins Metroplasty Yes No
- a delivery of a stillborn child by caesarian section as a result of premature labour anytime after the Tompkins Metroplasty Yes No
- surgical repair at anytime as a result of the Tompkins Metroplasty? Yes No

If you answered "Yes" to any of the questions above, include copies of the Patient's hospital or medical records which support the occurrence of the complication/intervention, its timing and that the Tompkins Metroplasty caused or materially contributed to its occurrence (include only the relevant portions of the hospital or medical records).

If you answered yes to one or more of the indicated complications/interventions, explain how the Tompkins Metroplasty materially contributed to each:

Did you treat the Patient for this/these medical complications / interventions? Yes No

If yes, indicate which medical complications/interventions you treated:

If you did not treat the Patient for this/these medical complications/interventions, on what do you base your opinion that the Tompkins Metroplasty materially contributed to the complications/interventions?

How long have you known the Patient? _____ How long have you treated the Patient? _____
(Years) (Years)

SECTION D - CERTIFICATION BY PHYSICIAN

I hereby certify that the information provided herein is true and correct to the best of my knowledge, information and belief.

Signed at _____ this _____ of _____ , _____
(City) (Day) (Month) (Year)

Physician's Signature