Biomet Hip Device Class Action
c/o Verita Global
P.O. Box 3355
London, ON N6A 4K3

Claimant Declaration

CLAIMANT DECLARATION

CANADIAN M2a 38, M2a MAGNUM and ReCAP FEMORAL RESURFACING SYSTEM METAL-ON-METAL CLASS ACTION

This form must be completed and returned to the Claims Administrator by electronic filing, mail or in person no later than **January 26, 2026**.

I am making a claim either myself or through counsel:

☐ as a Claimant who was implanted with any of the M2a 38, M2a Magnum or ReCap Femoral Resurfacing System, or any combination thereof, implanted in Canada and used as a metal-on-metal hip implant system ("**Biomet Device**").

☐ as the Representative (a person who is the personal representative of a Claimant who is deceased or under a legal disability) of a Claimant.

Section A: Claimant Information

First Name | Middle | Last Name

Date of Birth (dd/mm/yyyy) | Gender: ☐ Male ☐ Female ☐ Other

Address

City | Province/Territory | Postal Code

Daytime Phone Number | Cellular Phone Number

Email | Current Provincial Health Insurance Number ("PHN") (if applicable)

Did the Claimant's province of residence change since the time that the Claimant received a Biomet Device?

☐ Yes ☐ No

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

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 | Middle | Last Name

Date of Birth (dd/mm/yyyy)

Address

City | Province/Territory | Postal Code

Email | Date of Death of the Claimant (if applicable) (dd/mm/yyyy)

Daytime Phone Number | Cellular Phone Number

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, Last Will and Testament, Letters of Administration, etc.). If the Claimant is deceased, please also attach a copy of the Claimant's death certificate to this form.

☐ Power of Attorney

☐ Certificate of Incapacity

☐ Letters of Administration

☐ Will

☐ Death Certificate

☐ Grant of Probate

☐ Other. Please explain _____

Section C: Lawyer Information (if applicable)

Lawyer Last Name _____ Lawyer First Name _____

Name of Law Firm _____

Address _____

Phone Number _____ Email _____

Section D: Biomet Device Implant Information

Location of the Device: ☐ Right ☐ Left ☐ Bilateral

Implant Date (Right) _____
(dd/mm/yyyy)

Name of Hospital _____

Surgeon _____

Implant Date (Left) _____
(dd/mm/yyyy)

Name of Hospital _____

Surgeon _____

Identification stickers and operative report(s) for your Biomet Device(s) must be submitted with this Claimant Declaration.

Section E: Revision Information

Has the Claimant undergone a revision surgery or surgeries to remove the Biomet Device(s)?

☐ Yes ☐ No

If you checked "No," please skip to Section F below.

Location of Revision: ☐ Right ☐ Left ☐ Bilateral

Implant Revision Date (Right) _____
(dd/mm/yyyy)

Name of Hospital _____

Surgeon _____

Implant Revision Date (Left) _____
(dd/mm/yyyy)

Name of Hospital _____

Surgeon _____

Section F: Revision Medically Precluded

Has the Claimant's doctor recommended a revision, but also advised the Claimant that a revision is medically precluded?

☐ Yes ☐ No

If you checked "Yes," please submit with this form either: (i) medical records of other medical reports that explicitly state that you are medically precluded from undergoing revision surgery; or (ii) Physician's Declaration completed and signed by your physician. Complete the remainder of Section F.

If you checked "No," please skip to Section G.

Identify the name and address of the doctor who advised the Claimant, the date of discussion, and the medical condition(s) that prevents the Claimant from having the surgery. Please state whether the Claimant has been advised that the condition(s) will permanently prevent the Claimant from having revision surgery, as opposed to delaying a revision surgery.

_____

Date(s) of Discussion (MM/DD/YYYY)

_____

Doctor

_____

Address

Medical condition(s):_____

_____

_____

_____

Section G: Claimant's Immediate Family Information

Complete this section if the Claimant had a revision surgery or is medically precluded from having revision surgery.

If the Claimant had at least one Revision Surgery to remove a Biomet Device, please answer the following:

Did an adult spouse, child, grandchild, parent, grandparent, brother or sister provide the Claimant with care to assist in the Claimant's recovery after their revision surgery or surgeries to remove the Biomet Device(s)?

☐ Yes ☐ No

If you checked "Yes," list the family member's or members' name(s) and their relationship to the Claimant:

_____

Name(s) of Family Member(s) Relationship(s) to Claimant

Did the Claimant have children under the age of 18 who lived with them on the date of their revision surgery to remove the Biomet Device(s)?

☐ Yes ☐ No

If you checked "Yes," list the names and dates of birth:

Name	DOB: (dd/mm/yyyy)
Name	DOB: (dd/mm/yyyy)

If the Claimant is medically precluded from undergoing a revision surgery, please answer the following:

Did an adult spouse, child, grandchild, parent, grandparent, brother or sister provide the Claimant with care to assist in the Claimant's recovery after their surgery or surgeries to implant the Biomet Device(s)?

☐ Yes ☐ No

If you checked "Yes," list the family member's or members' name(s) and their relationship(s) to the Claimant:

Name(s) of Family Member(s)	Relationship(s) to Claimant

Did the Claimant have children under the age of 18 who lived with them on the date of their surgery to implant the Biomet Device(s)?

☐ Yes ☐ No

If you checked "Yes," list the names and dates of birth of those children:

Name	DOB: (dd/mm/yyyy)
Name	DOB: (dd/mm/yyyy)

Section H: 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.

	Date (dd/mm/yyyy)
Second Revision (surgery to remove a replacement hip implant that had been implanted as part of a Revision Surgery because the replacement hip device failed)	
Third Revision (surgery to remove a replacement hip implant that had been implanted as part of a Second Revision because the replacement hip device failed)	
Infection (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)	
Femoral Fracture (fracture of femur that occurs during a Revision Surgery or as a result of the Revision Surgery, and does not include fracture that results from trauma that occurs before or after the Revision Surgery)	
Dislocation (complete disassociation of femoral head and acetabular cup that occurs within 6 weeks of the Revision Surgery)	
Blood Clot (diagnosis made within 72 hours of a Revision Surgery of pulmonary embolism or deep vein thrombosis that resulted from a Revision Surgery)	
Stroke (cerebrovascular incident or insult occurring within 72 hours of a Revision Surgery and determined to have been caused by the Revision Surgery)	
Heart Attack (myocardial infarction or cardiac arrest occurring within 72 hours of a Revision Surgery and determined to have been caused by the Revision Surgery)	
Permanent Nerve Damage (nerve damage [including but not limited to meralgia paresthetica and foot drop caused by peroneal nerve damage] resulting from a Revision Surgery that is permanent as established by medical records or a Physician's Declaration, or that has persisted for 18 months or more)	
Death (class member died within 72 hours after a Revision Surgery as a result of the Revision Surgery)	
Lost Wages (economic loss supported by documentary evidence showing income loss in excess of 20% of the claimant's aggregate gross income for the two highest earning years in the four years preceding the Revision Surgery)	

To make a Post-Revision Complication claim (EXCEPT for a Lost Wages claim), you must submit the following with this form:

A) A Physician's Declaration documenting each complication; OR

B) Medical records or other medical reports, including operative reports, relating to each complication.

To make a Lost Wages claim, you must submit documentary evidence showing Post-Revision income loss in excess of 20% of the Claimant's aggregate gross income for the two highest earning years in the four years preceding the Revision Surgery. This documentary evidence shall include:

A) Income tax statements, T4s, Notices of Assessment, or similar documents from a recognized tax authority; OR

B) Employment records from before and after the Revision Surgery, meaning paystubs, employment letters, and similar documents.

Section I: Out-of-Pocket Expenses

Complete this section only if the Claimant had a revision surgery or is medically precluded from undergoing revision surgery.

☐ Check here if the Claimant purchased his or her Biomet Device(s) with his or her own funds (i.e., the cost of the implant was not paid by an insurer). If you checked the box, attach all receipts or other documentation reflecting the amount paid by the Claimant for the Biomet Device(s) to this form.

Did the Claimant (who has been revised or is medically precluded from undergoing a revision) incur any other out-of-pocket expenses in connection with a revision surgery, post-revision complications, or medical treatment?

☐ Yes ☐ No

If you checked "No," skip to Section J. If you checked "Yes," please answer the following: Are these claimed out-of-pocket expenses $2,500 or less?

☐ Yes ☐ No

If you checked "No," and you wish to seek reimbursement for the expenses you incurred that are greater than $2,500, you may complete and submit the Extraordinary Expense Pool Claim Form. Please note that you are required to provide receipts substantiating all of your out-of-pocket expenses if you seek reimbursement totaling more than $2,500. If you choose to complete the Extraordinary Expense Pool Claim Form, please attach the receipts substantiating the expenses you seek to recover up to $2,500 to this Claimant Declaration and attach the receipts substantiating any additional expenses you seek to recover to the Extraordinary Expense Pool Claim Form.

If you checked "Yes" above, or you seek to recover no more than $2,500 in out-of-pocket expenses, do you have receipts to substantiate the expenses you incurred?

☐ Yes ☐ No

If "Yes," please attach your receipts to this form. If "No," please state the approximate total of the expenses you incurred: $_____

The maximum amount which may be reimbursed for out-of-pocket expenses which are not documented by receipts is $750.

Section J: Declaration

I solemnly declare that:

The Claimant was implanted with one or more of M2a 38, M2a Magnum or ReCap Femoral Resurfacing System, or any combination thereof, in Canada that was used as a metal-on-metal hip implant system ("**Biomet Device**"). The Claimant wishes to make a claim for compensation in this class action.

Attached are copies of the Claimant's implant and revision (if applicable) operative reports, medical records and documentation which include identifying catalogue and lot numbers of the Claimant's Biomet Device(s). All complete operative reports, medical records and documentation have been submitted. If the information has not been submitted, it is because it is not available or within the Claimant's possession, custody, or control and cannot be obtained from the hospital or physician where treatment occurred.

If I am not submitting copies of the Claimant's Biomet Device(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 Biomet Device(s) in lieu of the Claimant's Biomet Device(s) peel and-stick labels, I cannot submit a photograph because the Claimant's Biomet Device(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	Date (mm/dd/yyyy)

Please note: All pages of this Declaration and supporting documents must be submitted to the Claims Administrator on or before the applicable Submission Deadline.