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

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

SPECIAL CLAIMS PROTOCOL CLAIM FORM

This form must be completed and returned to the Claims Administrator by electronic filing, email, mail or in person no later than:

1) If the Claimant is a **Metal Ion Claimant**, by January 26, 2026
2) If the Claimant is a **Late Index Surgery Claimant**, within 90 days of the Claimant's revision surgery
3) If the Claimant is as **12-16 Year Claimant**, within 90 days of the Claimant's revision surgery, and no later than March 31, 2031

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.

A Claimant who makes a claim as an **Unrevised Class Member** under the **Settlement Agreement** may also claim under the **Special Claims Protocol** as a **Metal Ion Claimant**, but may not also claim as a **Late Index Surgery Claimant** or as a **12-16 Year Claimant**.

□ I have submitted or will submit a claim under the **Settlement Agreement** as an **Unrevised Class Member**.

For information about these terms, please refer to the **Special Claims Protocol**, available online at www.biometdevicesettlement.com. You can get assistance with a claim under the **Special Claims Protocol** from one of the law firms in the class action by contacting one of them using the information at the end of this form.

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 | Mobile/Cell 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 | Mobile/Cell 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_____

If you already submitted a Claimant Declaration under the Settlement Agreement with copies of the documents that grant you the legal authority to act on behalf of the Claimant, you do not need to submit them again.

□ I submitted a claim under the **Settlement Agreement** and attached copies of the documents that grant me the legal authority to act on behalf of the Claimant.

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 Claim Form.

If you already submitted a Claimant Declaration under the Settlement Agreement with identification stickers and operative report(s), you do not need to submit them again

□ I submitted a claim under the **Settlement Agreement** and attached identification stickers and operative report(s).

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: Metal Ion Claims

To be eligible for compensation as a Metal Ion Claimant, the Claimant must be unrevised (must not have undergone a revision surgery).

The Claimant must also provide copies of medical records dated at least 180 days after their initial implant surgery with blood test results indicating cobalt or chromium levels which exceed any of the following thresholds:

	Serum (µg/L)	**Serum (nmol/L)**	**Whole Blood (µg/L)**	**Whole Blood (nmol/L)**
Cobalt	10 µg/L	169.5 nmol/L	9.14 µg/L	154.9 nmol/L
Chromium	10 µg/L	192.3 nmol/L	5.94 µg/L	114.2 nmol/L

Please attach copies of the Claimant's medical records including blood test results to this claim form.

Section G: 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 H: 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

Please note: All pages of this claim form and supporting documents must be submitted to the Claims Administrator on or before the applicable deadline.

You can get assistance with this claim form by contacting one of the law firms in the class action:

KOSKIE MINSKY LLP Barristers and Solicitors 20 Queen Street West, Suite 900, P.O. Box 52 Toronto ON M5H 3R3 Tel: 1-855-595-2629 Email: biometclassaction@kmlaw.ca **WHELTON HIUTIN LLP** Barristers and Solicitors 15 Toronto Street Suite 200 Toronto ON M5C 2E3 **J. Daniel McConville** Tel: 416.599.7900 Email: dmcconville@whlawyers.ca	**KLEIN LAWYERS** 100 King Street West Suite 5600 Toronto ON M5X 1C9 **Brent D. Ryan** Tel: 604.714.6154 Email: bryan@callkleinlawyers.com **SYLVESTRE PAINCHAUD & ASSOCIES** 740, Avenue Atwater Montréal, Québec, H4C 2G9 **Normand Painchaud** **Sophie Estienne** Tel: 514.937.2881 Email: biomet@spavocats.ca