COVID-19 KENT PHARMACY CLASS ACTION SETTLEMENT

CLAIM FORM

Private & Confidential

Please read this Claim Form carefully and complete it in full. Failure to fully complete this Claim Form and/or sign it will result in your Claim being rejected. Once completed and signed, submit this Claim Form to the Claims Administrator on or before September 30, 2026 at 5:00 P.M. (Pacific Standard Time).

This Claim Form is for Class Members who wish to claim compensation under the Settlement Agreement. **"Class Members"** means all persons resident in British Columbia who (1) attended at premises owned or operated by the Defendant, Kent Pharmacy, at 424 Columbia Street, New Westminster, British Columbia on August 24, 25 or 26, 2021 and received a COVID-19 vaccination, and which person is named and identified on a list of 96 people that received the subject COVID-19 vaccinations on August 24, 24 or 26, 2021 and (2) were contacted by the Fraser Health Authority by letter advising them that the syringe barrel was re-used among patients and that they were at risk of contracting hepatitis B, hepatitis C and/or human immunodeficiency virus ("HIV") and to take three blood tests over the next three months: at three weeks, six weeks and three month intervals.

CATEGORY/CATEGORIES OF CLAIM:

The proposed Settlement provides for the creation of two funds: Fund 1 in the amount of $307,200 and Fund 2 in the amount of $200,000, which will be used to pay compensation to Class Members including court-approved Class Counsel legal fees, disbursements, and applicable taxes.

Each approved Class Member will be entitled to a payment of up to a maximum of $3,200 from Fund 1 without proof of injury or damage. Each approved Class Member will be entitled to a further payment, up to a maximum of $5,000 from Fund 2, on establishing that they suffered psychological harm exceeding four months with proof of psychological or psychiatric treatment.

A. Fund 1

For Class Members making a claim on Fund 1 only please provide the following:

i. Full Name:_____

ii. Personal Health Number:_____

iii. Date of Birth:_____

B. Fund 2

For Class Members making a claim on Fund 2, in addition to the information required for those making a claim on Fund 1, such Class Members must provide the following:

i. a solemn declaration that they obtained treatment for psychological harm that they believe was caused by knowledge that they had received a COVID-19 vaccination with a syringe barrel that had been previously used, and that they received this treatment for a minimum of four months due to their psychological injury, with the treatment being provided by a psychologist, qualified and licensed to practice in British Columbia by the College of

Health and Care Professionals of British Columbia; or by a psychiatrist, licensed to practice in British Columbia, by the College of Physicians and Surgeons of British Columbia;

ii. a statement from their treating psychologist, qualified and licensed to practice in British Columbia by the College of Health and Care Professionals of British Columbia; or by their treating psychiatrist, licensed to practice in British Columbia by the College of Physicians and Surgeons of British Columbia. The statement from the treating psychologist or psychiatrist must be in the following form and include the following information:

> From _____until_____, being a period exceeding four months in duration, I treated_____ for psychological harm that in my opinion was caused by their reaction to a COVID-19 vaccination that they received from Kent Pharmacy at 424 Columbia Street, New Westminster, British Columbia on August 24, 25 or 26, 2021, which vaccination they understood to have been administered by a re-used syringe barrel. I confirm that I am a psychologist, qualified and licensed to practice in British Columbia by the College of Health and Care Professionals of British Columbia (registrant #_____) OR a psychiatrist, licensed to practice in British Columbia by the College of Physicians and Surgeons of British Columbia (registrant #_____).

1. Class Member Identification

Provide the following information about the person submitting this Claim, or, if applicable, on whose behalf you are submitting this Claim, **and provide proof of identity:**

First Name:		Middle Initial:
Last Name:		
Prior Names:		
Street Address:		Suite Number:
City:	Province:	Postal Code:
Phone Number:	Email Address:	
Date of Birth (dd/mm/yyyy):		

Documentation: Enclose a copy of a valid, government-issued photo ID that matches the name and contact information entered above.

2. Representative Identification (if you are submitting this Claim on behalf of a Class Member who is deceased or a minor or for another reason)

YOU ARE SUBMITTING THIS CLAIM ON BEHALF OF SOMEONE WHO IS:
☐ DECEASED ☐ A MINOR ☐ OTHER REASON (Identify):

If you are submitting this Claim as a representative on behalf of a Class Member, provide the following personal identification information **and attach a copy of the Certificate of Appointment of Estate Trustee, Power of Attorney or other document establishing your authority to act on this person's behalf:**

Representative's Full Name:		
Representative's Relationship to Class Member:		
Representative's Street Address:		Suite Number:
City:	Province:	Postal Code:
Representative's Phone Number:	Representative's Email Address:	
Representative's Law Firm Name (if applicable):		

3. Legal Counsel Identification (if applicable)

This section is to be completed only if a lawyer is representing the Class Member. Please note that if you complete Section 3 below, 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.

Law Firm Name:		
Lawyer's Full Name:		
Street Address:		Suite Number:
City:	Province:	Postal Code:

Phone Number:	Email Address:
Law Society Number:	

4. Information Regarding the Class Member's attendance at Kent Pharmacy

Provide the dates, between August 24 and 26, 2021, on which you received a COVID-19 vaccination at the Kent Pharmacy:

5. Information Regarding the Medical Professional(s) Who Diagnosed and/or Treated Your Psychological Harm

In the space below, list each licensed psychologist and/or psychiatrist who diagnosed and/or treated your psychological harm which you were diagnosed subsequent to receiving a COVID-19 vaccination at the Kent Pharmacy and that you claim resulted from Kent Pharmacy's alleged failure to safely administer the COVID-19 vaccination in breach of public health standards. **Please provide name(s), address(es) and phone number(s) for each such medical professional.**

6. Supporting Documentation

Note: Failure to provide supporting documentation will result in your Claim being rejected.

Attach to this Claim Form medical documentation from the licensed psychologist or psychiatrist who diagnosed you with psychological harm demonstrating the following: (i) that you suffered psychological harm arising from the COVID-19 vaccination administered at the Kent Pharmacy and which psychological harm exceeded four months; and (ii) the date of your psychological harm diagnosis. Please note that you **must** submit supporting medical documentation from your licensed

psychologist or psychiatrist showing that you suffered psychological harm for a minimum of four months to make a claim on Fund 2.

7. Privacy Statement

All personal information provided by or on behalf of the Class Member to the Claims Administrator will be handled in accordance with applicable privacy laws. Such information will be used solely for the purposes of administering the Settlement Agreement. The information provided will be treated as private and confidential and will not be disclosed without the express written consent of the Class Member, except in accordance with the Settlement Agreement, the Settlement Approval Order and/or other orders of the Supreme Court of British Columbia.

8. Signature & Date

By signing below, I declare under penalty of perjury that I am a Class Member or a representative of a Class Member as disclosed in Section 2 above, and that the information provided and submitted in this Claim Form is true and correct to the best of my knowledge. I understand that this Claim Form and the supporting documentation attached hereto may be subject to audit, verification, and review by the Claims Administrator and/or Court. I also understand that if the information in this Claim Form or the supporting documentation attached hereto is believed or found to be fraudulent, I will not receive any payment. I agree to participate in the proposed Settlement.

Date	Signature of Class Member (or Representative)
	Printed Name of Class Member (or Representative)
Date	Signature of Class Member's Lawyer (if any)
	Printed Name of Class Member's Lawyer

9. Reminder Checklist

I have reviewed this Claim Form for completeness and correctness.

I have signed and dated this Claim Form.

I have attached the required supporting medical documentation for psychological harm under Fund 2.

I have made a copy and kept a copy of this Claim Form and all supporting documentation for my records.

10. Submit this Claim Form (with required supporting documentation attached)

Once completed and signed, submit this Claim Form with the required supporting documentation attached to the Claims Administrator by mail, courier or email at the Claims Administrator's contact information below **on or before September 30, 2026 at 5:00 P.M. (Pacific Standard Time).**

If you fail to submit this Claim Form and/or supporting evidence and documentation on or before **September 30, 2026 at 5:00 P.M. (Pacific Standard Time)**, you will not be eligible for any compensation whatsoever (i.e., you will not get paid). Sending in a Claim Form late will be the same as doing nothing.

Attn: Kent Pharmacy Class Action Settlement Claims Administrator
MNP Ltd.
2000, 112-4th Avenue SW
Calgary, AB T2P 0H3
1-833-680-3637
kentpharmacysettlement@mnp.ca

Please note that after the Claims Period has concluded and if the Claims Administrator determines that your Claim is successful, the Claims Administrator will then complete a successful claims report and provide it to counsel for the Parties in this matter. Accordingly, the Claims Administrator will mail the individual compensation cheques within approximately sixty (60) days after the successful claims report has been sent to counsel for the Parties. This process will take some time and is subject to further change, and your patience is appreciated. When the cheques have been mailed, an announcement will be posted on Class Counsel's website at (www.dusevicgarcvhalaw.ca). Please check Class Counsel's website periodically for updates on the status of the proposed Settlement.

If you have any questions about this Claim Form or the proposed Settlement generally, please visit Class Counsel online at (www.dusevicgarchalaw.ca) or email info@dusevicgarchalaw.ca or call Class Counsel at 604-436-3315 or 1-844-878-0444.

This Notice was approved by order of the Supreme Court of British Columbia.