

Claim Package

LEVAQUIN, CIPROFLOXACIN and AVELOX Settlement

This Claim Package contains:

- A Privacy Statement;
- Instructions for Claimants; and
- A Claim Form

PRIVACY STATEMENT

Personal Information regarding Claimants is collected, used, and retained by the Class Counsel pursuant to the Personal Information Protection and Electronics Documents Act. S.C. 2000, c.5 (PIPEDA):

- For the purpose of administering the Janssen Settlement Agreement and Bayer Settlement Agreement ("Settlement");
- To evaluate and consider the Claimant's eligibility under the Settlement; and
- Is strictly private and confidential and will not be disclosed without the express written consent of the Claimant except as provided for in the Settlement.

INSTRUCTIONS FOR CLAIMANTS

Please note that no Claims will be processed unless and until the Settlement has been approved by the Supreme Court of British Columbia.

Unless otherwise indicated herein, capitalized terms have the meanings set out in the Janssen Settlement Agreement and Bayer Settlement Agreement.

These instructions provide basic guidelines for submitting claims under the Settlement. In the case of any disagreement between these instructions and the Settlement, the Settlement shall prevail. For more detailed information, please refer to the Janssen Settlement Agreement and Bayer Settlement Agreement, and other documents, that can be viewed or downloaded at www.garchaandcompany.ca.

To establish your right to benefits under the terms and conditions of the Settlement, a completed Claim Package must be submitted to Class Counsel which shall consist of:

- A completed and signed Claim Form;
- Product Identification Documentation;
- Mandatory Medical Records; and
- All other required documentation as described herein.

All completed Claim Packages must be submitted to Class Counsel postmarked on or before **May 2, 2025**, at the following address or email:

LEVAQUIN, CIPROFLOXACIN AND AVELOX SETTLEMENT

Class Counsel
Dusevic & Garcha
#210 - 4603 Kingsway
Burnaby, BC, V5H 4M4 Canada
Email: ksgarcha@dusevicgarchalaw.ca

Claimants who have not opted out and who do not submit a completed Claim Package to Class Counsel on or before **May 2, 2025**, shall forever forfeit their rights to benefits from the Settlement and will be precluded from ever bringing an action against any of the Released Parties with respect to the Released Claims.

Class Counsel's decision respecting the eligibility and validity of any submitted Claim herein shall be final and binding. There shall be no right of appeal of Class Counsel's decisions thereto by any Claimant herein respecting any such submitted Claim. In administering the Settlement no suit, proceedings, claims, causes of action and/or assertions of rights, past, present or future, shall lie and/or be commenced against Class Counsel by any Claimant herein as to Class Counsel's decision respecting the eligibility and validity of any submitted Claim herein and administering the Settlement.

If you require assistance or advice regarding completion of the Claim Package or have any questions related to your claim, you may retain legal counsel at your own expense, or contact Class Counsel, free of charge at 1-844-878-0444, or at www.garchaandcompany.ca. Claimants who retain lawyers or agents in making their claims under the Settlement shall be solely responsible for the fees and expenses of such lawyers or agents.

Claimants may communicate with Class Counsel and obtain forms. Claimants (or their lawyers/agents) should advise Class Counsel of any changes or corrections in address, name, phone number or legal representation.

Please keep copies of all documentation you send to Class Counsel. Completing the documentation process takes time. **ACT NOW**. Do not wait until the last few weeks before the Claim Deadline period expires.

Claim Form

LEVAQUIN, CIPROFLOXACIN AND AVELOX SETTLEMENT

Strictly Private and Confidential

Section 1: Claimant Identification

I am making a claim as a:

☐ **Class Member**
(the person who used or ingested brand name (non-generic)
Levaquin, Ciprofloxacin or Avelox)

☐ **Representative of a Class Member**
(a person who is the legal representative of a Class Member who is
deceased, a minor and/or otherwise under a legal disability)

Section 2: Class Member Information

Class Member Last Name

First Name

Street Address

P.O. Box

City

Province

Postal Code

Birth Date:
YYYY/MM/DD

Date of Death (if
applicable): YYYY/MM/DD

☐ Official Death
certificate attached

Home phone

Work phone

Fax

E-mail

Section 3: 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. Before completing this section, you MUST complete Sections 1 and 2 to identify yourself and the Class Member that you are representing.

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

- ☐ **A minor (under 18 years of age)**
Please enclose a copy of your authority to act (i.e., long-form birth certificate, baptismal certificate, court order or other proof of guardianship)
- ☐ **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, etc.)

Representative Claimant Last Name

First Name

Street Address

P.O. Box

City

Province

Postal Code

Birth Date:
YYYY/MM/DD

Home phone

Work phone

Fax

E-mail

Section 4: Family Class Member Claim

This section is to be completed ONLY if you are submitting a claim for a Family Class Member. A Family Class Member who is entitled to advance a claim include a spouse and/or child of a Class Member for whom a claim is being advanced under the Settlement.

Please include document(s) demonstrating proof of the Family Class Member's relationship to the Class Member and, where the Family Class Member is a minor, under a legal disability or deceased, please include document(s) demonstrating proof of your authority to act (e.g., marriage certificate, long-form birth certificate, baptismal papers, separation agreement, custody judgment, divorce judgment or affidavit, will or other document confirming your authority to act).

Before completing this section, you MUST complete Sections 1 and 2 to identify the Class Member who is your source of entitlement to make a claim. If there is/are more than one Family Class Member making a claim, please copy this section and provide the requested information for each Family Class Member and submit with your Claim Package.

Family Class Member Last Name

First Name

Street Address

P.O. Box

City

Province

Postal Code

Birth Date:

YYYY/MM/DD

Home phone

Work phone

Fax

E-mail

Section 5: Legal Representative Identification

This section is to be completed ONLY if a lawyer or agent is representing the Claimant.

Name of Law Firm or Agency

Lawyer or Agent's Last Name

First Name

Street Address

P.O. Box

City

Province

Postal Code

Phone number

Fax

E-mail

Provincial Law Society (if applicable)

NOTE: If you complete Section 5 above, all correspondence will be sent to your legal representative, who must notify Class Counsel of any change in mailing address. If you change your legal representation or cease to retain your legal representative, you **MUST** notify your former legal representative and Class Counsel in writing.

Section 6: Products Prescribed

Please indicate whether the Class Member was prescribed any or all of the following:

Levaquin	☐ Y	☐ N
Ciprofloxacin	☐ Y	☐ N
Avelox	☐ Y	☐ N

You must provide Product Identification Documentation sufficient to prove that the Class Member was prescribed and/or provided brand name (non-generic) Levaquin, Ciprofloxacin or Avelox. You must provide one or more of the following forms of Product Identification Documentation set out below:

- a) all pharmacy records reflecting the dispensing of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox to the Class Member, including the dosage and dates(s) of same;

AND/OR

- b) all insurance records reflecting the Class Member's purchase of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox including the dosage and dates of same, if available;

AND/OR

- c) medical records and/or government pharmanet records reflecting the prescription and/or provision of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox to the Class Member, along with the dosage and dates of same

OR

- d) in extraordinary circumstances only, to be determined by Class Counsel if none of the above records are available, a declaration signed by the Class Member's physician attesting to the Class Member having been prescribed and/or provided with brand name (non-generic) Levaquin, Ciprofloxacin or Avelox, including the dosage and dates of same, along with a statutory declaration by the Class Member (or the Class Member's representative) that the Class Member was prescribed and/or provided with brand name (non-generic) Levaquin, Ciprofloxacin or Avelox, along with the dosage and dates of same, and affirming that they have made reasonable best efforts to obtain the above records and providing the reason why such records could not be obtained.

Section 7: Alleged Peripheral Neuropathy Compensable Injury

Please indicate the Class Member's alleged Peripheral Neuropathy compensable injury which forms the basis of this claim along with date(s) of diagnosis and/or treatment (note that compensation is only available once per claim). Payment of a benefit under the Settlement for a Peripheral Neuropathy compensable injury to an eligible Class Member is inclusive of all pecuniary and non-pecuniary damages.

"Peripheral Neuropathy" means a nerve disorder occurring in the arms or legs with associated symptoms of paresthesia, hypoesthesia, dysesthesia, weakness, numbness, pain, discomfort, burning, tingling, or other alterations of sensation including, light touch, pain temperature, position sense and vibration sensation, and diagnosed as peripheral neuropathy by a medical professional.

A person will not be entitled to compensation from the Settlement unless they have established both that: (i) they used or ingested brand name Levaquin, Ciprofloxacin and/or Avelox; and (ii) they did so within sixty (60) days of developing Peripheral Neuropathy.

1. Are you claiming a Peripheral Neuropathy injury as a result of using or ingesting brand name (non-generic) Levaquin, Ciprofloxacin or Avelox?

If yes, please describe in detail any Peripheral Neuropathy injury you claim were caused as a result of your use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox.

2. Date you first experienced symptoms of Peripheral Neuropathy following use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox?

3. Have you ever been treated by a health care provider (other than a hospital) for Peripheral Neuropathy following use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox?

Yes: _____ No: _____

If yes, please provide the following information:

a. Approximate date(s) of treatment: _____

b. Name and address of healthcare providers:

4. Are you claiming that your use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox caused you to develop Peripheral Neuropathy?

Yes: _____ No: _____

If yes, please answer the following questions:

a. Have you been diagnosed with Peripheral Neuropathy? Yes: _____ No: _____

b. What healthcare provider diagnosed you with Peripheral Neuropathy and when? _____

- c. Date you first experienced Peripheral Neuropathy symptoms? _____
- d. What treatment have you undergone or are you undergoing? _____
- e. What treatment options were considered? _____
- f. Did the condition resolve? Yes: _____ No: _____

5. Have you ever been hospitalized as a result any of these Peripheral Neuropathy conditions or injuries?

6. Yes: _____ No: _____

a. Approximate date(s) of hospital admissions: _____

b. Approximate date(s) of discharge: _____

c. Hospital name(s) and address(es): _____

7. Have you had any communications with your healthcare providers, orally or in writing, about whether your Peripheral Neuropathy is related to your use or ingestion of brand name Levaquin, Ciprofloxacin and/or Avelox?

Yes: _____ No: _____

If yes, please identify the name, address, and approximate date of communication with said healthcare provider: _____

Section 8: Pre-Existing Peripheral Neuropathy Condition

Please indicate if the Class Member experienced or suffered from a pre-existing Peripheral Neuropathy condition. Please note that this information is intended to assist with the review of your Claim Package. Class Counsel will make any and all determinations as to whether the Class Member experienced or suffered from a pre-existing Peripheral Neuropathy condition as to approving or denying any submitted Claim following its review of the Class Member's Mandatory Medical Records.

1. Was the Class Member diagnosed with Peripheral Neuropathy and any associated symptoms prior to first use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox

☐ Yes Date of diagnosis (YYYY/MM/DD)

☐ No

2. Did/does the Class Member have a history of Peripheral Neuropathy?

☐ Yes ☐ No

☐ Within one year prior to the date of the Class Member's Peripheral Neuropathy diagnosis **OR**

☐ Between one and five years prior to the date of the Class Member's **Peripheral Neuropathy diagnosis; OR**

☐ More than five but less but less than twenty years prior to the to Class Member's Peripheral Neuropathy diagnosis.

3. Did the Class Member have symptoms of Peripheral Neuropathy

PRIOR to first use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox?

Yes No Date of diagnosis (YYYY)MM/DD

Yes No

4. Was the Class Member's Peripheral Neuropathy diagnosis made more than sixty (60) days **AFTER** their last use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox?

☐ Yes

☐ No

Section 9: Mandatory Medical Records

Please ATTACH and SUBMIT all Mandatory Medical Records with your Claim Package.

Mandatory Medical Records include the documentation described below which you are required to submit in order to be eligible for benefits for a Peripheral Neuropathy compensable injury.

■ Medical Records reflecting the Class Member's Peripheral Neuropathy diagnosis, and which must include:

■ Any and all hospital records confirming the diagnosis of Peripheral Neuropathy following use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox.

OR

■ If no hospital record is available, other contemporaneous medical records or reports referencing a diagnosis of Peripheral Neuropathy following use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox.

AND



AND Complete medical records from all healthcare providers who diagnosed and/or provided the Class Members with treatment for their Peripheral Neuropathy following use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox.



AND If not included in the above, complete medical, government pharmacy and/or prescription records from all healthcare providers who prescribed brand name (non-generic) Levaquin, Ciprofloxacin or Avelox to the Class Member from the date of such first prescription through to the Class Member's last use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox.



AND

■ If not included in the above, complete medical records from the Class Member's primary health care provider for the period spanning three (3) years prior to the Class Member's Peripheral Neuropathy diagnosis through to the date of the Class Member's Peripheral Neuropathy diagnosis following use or ingestion of brand name (non-generic) Levaquin, Ciprofloxacin or Avelox.



Section 10: Claimant Declaration

The undersigned hereby consent(s) 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 a document approved by the Supreme Court of British Columbia that presides over the Settlement, and submitting this Claim Form to Class Counsel is equivalent to filing it with a court.

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.

Signature of Claimant



Print Name



Date (YYYY/MM/DD)



Section 11: Physician Declaration

This Section is to be completed ONLY if you were UNABLE to obtain and provide the Product Identification Documentation required by Section 6 above.

I solemnly declare that:

1. I am a physician licensed to practice medicine in the province of
2. I am/was a treating physician for (Class Member)
- and I hereby solemnly affirm that the Class Member was prescribed and/or provided with brand name (non-generic) Levaquin, Ciprofloxacin or Avelox as follows:

Levaquin	Yes	No
Date(s), duration, and dosage(s)	☐	☐
Ciprfloxacin	☐ Yes	☐ No
Date(s), duration, and dosage(s)		
Avelox	☐ Yes	☐ No
Date(s), duration, and dosage(s)		

Signature of Physician	Date
Name of Physician	
Address	
Telephone number	

Section 12: Claimant Declaration – Missing Product Identification Documentation

This Section is to be completed ONLY if you were unable to obtain and provide the Product Identification Documentation required by Section 6 above.

The undersigned hereby declares under penalty of perjury that the Class Member was prescribed, purchased, used and ingested brand name (non-generic) Levaquin, Ciprofloxacin or Avelox and developed Peripheral Neuropathy within sixty (60) days of such use and/or ingestion as follows:

Levaquin ☐ Yes ☐ No

Date(s), duration, and dosage(s)

Ciprofloxacin ☐ Yes ☐ No

Date(s), duration, and dosage(s)

Avelox ☐ Yes ☐ No

Date(s), duration, and dosage(s)

The undersigned affirms that reasonable best efforts were made to obtain the required Product Identification Documentation and the following are the reasons WHY such Product Identification Documentation could not be obtained and provided (please attach additional sheets if needed):

Signature of Claimant

Date