Exhibit "A"

CANADIAN ABILIFY® AND ABILIFY MAINTENA® CLASS ACTION SETTLEMENT

Claim Package

This Claim Package contains:

- a Privacy Statement;
- instructions for Class Members and their legal representatives (if applicable); and
- a Claim Form.

Claim package

PRIVACY STATEMENT

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

- for the purpose of operating and administering the Canadian ABILIFY® and ABILIFY MAINTENA® Settlement Agreement ("Settlement");
- to evaluate and consider the Class Member's eligibility under the Settlement; and
- is strictly private and confidential and will not be disclosed without the express written consent of the Class Member except as provided for in the Settlement.

INSTRUCTIONS FOR CLASS MEMBERS

If you are completing this Claim Package PRIOR to the Courts' approval of the Settlement, PLEASE NOTE that no Claims will be processed unless and until the Settlement has been approved by both the Ontario and Québec Courts.

Unless otherwise indicated in this document, capitalized terms have the meanings set out in the Settlement.

These instructions provide basic guidelines for submitting claims under the Settlement. In the event of any disagreement between these instructions and the Settlement, the Settlement shall prevail. For more detailed information, please refer to the Settlement Agreement that can be

viewed or downloaded at abilifyclassactionsettlement.com or the website of Class Counsel, Rochon Genova LLP and Consumer Law Group Inc.

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

- a completed and signed Claim Form;
- prescription records and/or medical records;
- Documentation relevant to Compulsive Behaviours or Impulse Control Behaviours where a claim for Psychological Harm, Severe and/or Residual Catastrophic Injury is made;
- Gambling Records and/or Financial Records where a claim for financial loss is made;
- Family Class Member(s)' records where Family Class Members claims are made; and
- all other required documentation as described in this document.

All completed Claim Packages must be submitted to the Claims Administrator or postmarked no later than November 12, 2025, at the following address:

Attention: Canadian ABILIFY® and ABILIFY MAINTENA®
Class Action Settlement
MNP Ltd. – Class Actions Claims Administration
2000, 112 - 4th Avenue SW
Calgary, AB, T2P 0H3
abilifysettlement@mnp.ca
Toll-Free: 1 (855) 653-0027

Class Members who have not opted out and who do not submit a completed Claim Package to the Claims Administrator on or before **November 12, 2025,** shall forever forfeit their rights to benefits from the Settlement and will be precluded from ever bringing an action against any of the Defendants or other Released Parties with respect to any alleged Compulsive Behaviours or Impulse Control Disorders caused by ABILIFY® and ABILIFY MAINTENA® and any other Released Claim.

If you require assistance or advice regarding completion of the Claim Package or have any questions related to your claim, you may contact Class Counsel or the Claims Administrator:

Class Counsel	Claims Administrator
ROCHON GENOVA LLP Tel: (416) 363-1867 1-800-462-3864 contact@rochongenova.com **CONSUMER LAW GROUP INC.** Tel: 1 (888) 909-7863 (514) 266-7863 (613 627-4894 abilify@clg.org	**MNP Ltd. – Class Actions Claims Administration** 1-800-538-0009 abilifysettlement@mnp.ca.

Alternatively, you may retain legal counsel at your own expense. **Class Members 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.**

Class Members may communicate with the Claims Administrator and obtain forms in either English or French. Class Members (or their lawyers/agents) should advise the Claims Administrator of any changes or corrections in the address, name, phone number or legal representation.

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

CANADIAN ABILIFY® AND ABILIFY MAINTENA® SETTLEMENT CLAIM FORM

Strictly Private and Confidential

Section 1 – Class Member Identification

I am making a claim as a:

- ☐ **Class Member** (the person who used ABILIFY® and/or ABILIFY MAINTENA®)
- ☐ **Representative of a Class Member** (a person who is the representative of a Class Member who is deceased, a minor and/or otherwise under a legal disability, including an individual with legal control over the Class Member's financial and property interest)
- ☐ **Lawyer or agent for the Class Member**

Section 2 – Class Member Identification

This section is to be completed by or on behalf of the Class Member. Please NOTE: If someone else has legal control over your property or finances, they MUST complete and submit Section 3 for your Claim to be processed.

Class Member Last Name:_____First Name_____

Address_____P.O. Box_____

City_____Province_____Postal Code_____

Birth Date: Year:_____Month:_____Day:_____

Date of Death (if applicable): Year_____Month_____Day_____

☐ Official Death certificate attached

Home Phone_____-_____-_____Work Phone ----------_____

Fax---------- _____E-mail _____

Section 3 – Representative of Class Member – Identification

This section is to be completed <u>only</u> 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. <u>Before completing this section, you MUST complete Sections 1 and 2 to identify yourself and the Class Member that you are representing.</u>

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, death certificate, probate order, etc.)

Legal Representative's Last Name:_____First Name_____

Address_____P.O. Box_____

City_____Province_____Postal Code_____

Birth Date: Year:_____Month:_____Day:_____

Home Phone_____-_____-_____Work Phone----------_____

Fax---------- _____E-mail_____

Section 4 – Family Class Member Claims

This section is <u>to be completed by eligible Family Class Members</u>. Eligible Family Class Members are spouses, children, parents, grandparents, brothers, and sisters of a Class Member by or for whom a claim is being advanced under the Settlement. If the Family Class Member is a minor, under a legal disability or deceased, this section may be completed by someone with authority to act on their behalf.

Please note that a Family Class Member is only entitled to claim compensation if the Class Member has not opted out of the class action **<u>and</u>** is submitting a claim to receive benefits under the Settlement.

<u>Please include document(s) demonstrating proof of each 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</u> (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).

<u>Before completing this section, you MUST complete Sections 1 and 2 to identify the Class Member who is entitled to make a claim. If there is/are more than one Family Class Member making a claim, please copy this section and have each eligible Family Class Member provide the requested information and submit this information along with your Claim Package.</u>

Relationship to Class Member:_____

Family Class Member Last Name:_____First Name:_____

Address_____P.O. Box_____

City_____Province_____Postal Code _____

Birth Date: Year_____ Month_____Day_____

Home Phone_____-_____-_____Work Phone----------_____

Fax---------- _____E-mail _____

Signature of Family Class Member:

_____

Section 5 – Legal Representative Identification

This section is to be completed ONLY IF a lawyer or agent is representing the Class Member.

Name of Law Firm or Agency_____

Lawyer's or Agent's Last Name:_____First Name:_____

Address_____P.O. Box_____

City_____Province_____Postal Code _____

Phone -_____-_____Fax---------- _____

E-mail _____

Provincial Law Society Number (if applicable) _____

NOTE: If you complete Section 5 above, all correspondence will be sent to the Class Member's legal representative, who must notify the Claims Administrator 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 the Claims Administrator in writing.

Section 6 – Products Prescribed and Used

Please indicate whether the Class Member was prescribed or provided with free sample packages of any or all of the following:

ABILIFY®	☐ YES	☐ NO
ABILIFY MAINTENA®	☐ YES	☐ NO

You must provide **all available prescription records and/or medical records** for the period of the Class Members' usage of ABILIFY® and/or of ABILIFY MAINTENA® to prove that the Class Member was prescribed and/or provided ABILIFY® and/or ABILIFY MAINTENA®. You must provide **one or more** of the following forms of documentary support set out below:

a) pharmacy records reflecting the dispensing of ABILIFY® and/or ABILIFY MAINTENA® to the Class Member, including the dosage and date(s) of same;

AND/OR

b) all insurance records reflecting the Class Member's purchase of ABILIFY® and/or ABILIFY MAINTENA®, including the dosage and dates of same, if available;

AND/OR

c) medical records reflecting the prescription and/or provision (samples) of ABILIFY® and/or ABILIFY MAINTENA ® to the Class Member, along with the dosage and dates of same;

OR

d) in extraordinary circumstances only, to be determined by the Claims Administrator, 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 ABILIFY® and/or ABILIFY MAINTENA®, including the dosage and dates of same, **AND** a declaration by the Class Member (or the Class Member's representative) that the Class Member was prescribed and/or provided with ABILIFY® and/or ABILIFY MAINTENA®, along with the dosage and dates of same, and attesting 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 –Psychological Harm

Please indicate the Class Member's alleged **Compensable Injury** which forms the basis of this claim along with date(s) of diagnosis and/or treatment (you may check all that apply but note that compensation is only available once per claim, at the highest confirmed injury level, regardless of the number of potential Compensable Injuries). Please note that this information is intended to assist with the review of your Claim Package. The Claims Administrator is entitled to make any and all determinations in respect of the appropriate Compensable Injury following its review of the Class Member's Mandatory medical records:

1) Mild:

☐ The Class Member took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **1-6 months <u>and</u>** experienced one or more of the following Compulsive Behaviours or Impulse Control Disorders while on or within 3 months of discontinuing their use of ABILIFY® and/or receiving injections of ABILIFY MAINTENA® (check all that apply):

- ☐ Compulsive gambling
- ☐ Hypersexuality
- ☐ Binge eating
- ☐ Compulsive or Uncontrollable shopping

DATES DURING WHICH BEHAVIOURS OCCURRED:

_____

☐ A signed attestation **(Section 7A)** that the Class Member took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **1-6 months <u>and</u>** experienced one or more of the above Compulsive Disorders or Impulse Control Disorders while on or within 3 months of discontinuing their use of ABILIFY® and/or receiving injections of ABILIFY MAINTENA®.

2) Moderate:

☐ The Class Member took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **more than 6 months <u>and</u>** experienced one or more of the following Compulsive Behaviours or Impulse Control Disorders (check all that apply) while or after taking ABILIFY® and/or receiving injections of ABILIFY MAINTENA®:

- ☐ Compulsive gambling
- ☐ Hypersexuality
- ☐ Binge eating
- ☐ Compulsive or Uncontrollable shopping

DATES DURING WHICH BEHAVIOURS OCCURRED:

_____

☐ A signed attestation **(Section 7A)** from the Class Member that they took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **more than 6 months <u>and</u>** experienced one or more Compulsive Behaviours or Impulse Control Disorders while on or within 3 months of discontinuing their use of ABILIFY® or receiving injections of ABILIFY MAINTENA®

OR

☐ The Class Member took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **1-6 months <u>and</u>**, while on or within 3 months of discontinuing their use of ABILIFY® and/or receiving injections of ABILIFY MAINTENA®, experienced one or more of the following Compulsive Behaviours or Impulse Control Disorders of such severity that treatment or counselling was sought for the Compulsive Behaviours or Impulse Control Disorders in question (check all that apply):

- ☐ Compulsive gambling
- ☐ Hypersexuality
- ☐ Binge eating
- ☐ Uncontrollable shopping

Please identify and attach medical records specifying the form of treatment or counselling sought or provided and the specific Compulsive Behaviour or Impulse Control Disorders for which treatment or counselling was sought or provided. If the treatment in question was not covered by provincial health insurance, attach receipts or confirmation of payment. Check all forms of applicable treatment or counselling:

- ☐ Gambling counselling
- ☐ Hypersexuality clinic
- ☐ Binge eating clinic
- ☐ Uncontrollable shopping clinic

DATES DURING WHICH BEHAVIOURS OCCURRED:

DATES DURING WHICH SPECIALIZED COUNSELLING OR TREATMENT WAS SOUGHT OR RECEIVED:

_____

□ A signed attestation **(Section 7A)** from the Class Member that they took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **1-6 months** and, while on or within 3 months of discontinuing their use of ABILIFY® or receiving injections of ABILIFY MAINTENA ®, they experienced one or more Compulsive Disorders or Impulse Control Disorders of such severity that treatment or counselling was sought for the Compulsive Behaviours or Impulse Control Disorders in question.

3) Severe:

□ The Class Member took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **more than 6 months <u>and</u>** experienced one or more of the below Compulsive Behaviours or Impulse Control Disorders while on or within 3 months of discontinuing their use of ABILIFY® or receiving injections of ABILIFY MAINTENA® (check all that apply):

☐ Gambling counselling

☐ Hypersexuality clinic

☐ Binge eating clinic

☐ Uncontrollable shopping clinic

<u>AND</u>

□ The Class Member experienced bankruptcy, divorce, re-mortgaging of a property, and/or criminal prosecution for fraud, theft, etc. contemporaneous to or after experiencing Compulsive Behaviours and/or Impulse Control Disorders, check all that apply:

☐ Declaration of Bankruptcy

☐ Divorce

☐ Re-mortgaging a property

☐ Criminal prosecution

☐ Other _____

Identify and attach records demonstrating that you experienced the Compulsive Behaviours or Impulse Control Behaviours (e.g. gambling records, such as ATM withdrawals at casinos, self-exclusion from a casino, credit card or banking statements showing payments for gambling, medical records referencing the Compulsive Behaviors, or medical records or counselling records documenting that treatment was sought for Compulsive Behaviours or Impulse Control Disorders), together with a signed attestation available under **Section 7A** that you experienced the Compulsive

Behaviours or Impulse Control Disorders and experienced bankruptcy, divorce, re-mortgaging of a property, and/or criminal prosecution for fraud, theft, etc. contemporaneous to or after experiencing the Compulsive Behaviours and/or Impulse Control Disorders

AND

Documentary evidence of bankruptcy, divorce, re-mortgaging of a property, and/or criminal prosecution for fraud, theft, etc. contemporaneous to or after experiencing Compulsive Behaviours and/or Impulse Control Disorders, check all that apply:

☐ Declaration of Bankruptcy

☐ Divorce

☐ Re-mortgaging a property

☐ Criminal prosecution

☐ Other _____

DATES DURING WHICH BEHAVIOURS OCCURRED:

_____

DATES OF BANKRUPTCY, DIVORCE, RE-MORTGAGING OF A PROPERTY, AND/OR CRIMINAL PROSECUTION FOR FRAUD, THEFT, ETC.:

_____

OR/ AND (if applicable)

☐ The Class Member experienced one or more of the following Compulsive Behaviours or Impulse Control Disorders while on or within 3 months of discontinuing their use of ABILIFY® or receiving injections of ABILIFY MAINTENA®, and the Compulsive Behaviours or Impulse Control Disorders were of such severity that treatment or counselling was sought for the Compulsive Behaviours or Impulse Control Disorders in question **for more than 6 months** (check all that apply):

☐ Compulsive gambling

☐ Hypersexuality

☐ Binge eating

☐ Uncontrollable shopping

Identify and attach records demonstrating that the Class Member experienced Compulsive Behaviours or Impulse Control Disorders (e.g. gambling records, such as ATM withdrawals at casinos, self-exclusion from a casino, credit card or banking statements showing payments for gambling, medical records referencing the compulsive behaviors, or medical records or counselling records documenting that treatment was sought for Compulsive Behaviours or Impulse Control Disorders), together with a signed attestation, available under **Section 7A,** that you experienced the Compulsive Behaviours or Impulse Control Disorders of such severity that treatment or counselling was sought for the Compulsive Behaviours or Impulse Control Disorders in question **for more than 6 months**. Check all forms of applicable treatment or counselling:

- ☐ Gambling counselling
- ☐ Hypersexuality clinic
- ☐ Binge eating clinic
- ☐ Compulsive or Uncontrollable shopping clinic

Identify and attach medical records specifying the form of treatment or counselling sought or provided and the specific Compulsive Behaviour or Impulse Control Disorders for which treatment or counselling was sought or provided. If the treatment in question was not covered by provincial health insurance, attach receipts or confirmation of payment. Check all forms of applicable treatment or counselling:

- ☐ Gambling counselling
- ☐ Hypersexuality clinic
- ☐ Binge eating clinic
- ☐ Uncontrollable shopping clinic

DATES DURING WHICH BEHAVIOURS OCCURRED:

_____

DATES DURING WHICH SPECIALIZED COUNSELLING OR TREATMENT WAS SOUGHT OR RECEIVED:

_____

4) Residual Catastrophic Injury (compensation available for catastrophic injury <u>in addition to</u> compensation available for Mild, Moderate and Severe Psychological Harm):

☐ Class Members claiming in this category must also claim for compensation under the Mild, Moderate, or Severe Psychological Harm category, above, and must provide documentary evidence demonstrating they:

i) experienced catastrophic physical or psychological consequences of Compulsive Behaviours or Impulse Control Disorders alleged to have been caused by the use of ABILIFY® and/or ABILIFY MAINTENA®, including but not limited to: contracting HIV, Hepatitis, or a non-treatable STI (sexually transmitted infection) as a result of hypersexuality, suicidality and related hospitalization related to Compulsive Behaviours or Impulse Control Disorders and their consequences. Specifically, they experienced (attach additional sheets if needed):

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7A – CLASS MEMBER'S ATTESTATION

MILD:

- ☐ The Class Member took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **1-6 months <u>and</u>** experienced one or more of the following Compulsive Behaviours or Impulse Control Disorders while on or within 3 months of discontinuing their use of ABILIFY® or receiving injections of ABILIFY MAINTENA® (check all that apply):
  - ☐ Compulsive gambling
  - ☐ Hypersexuality
  - ☐ Binge eating
  - ☐ Compulsive or Uncontrollable shopping

MODERATE:

- ☐ The Class Member took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **more than 6 months <u>and</u>** experienced one or more of the following Compulsive Behaviours or Impulse Control Disorders (check all that apply) while or within 3 months of discontinuing their use of ABILIFY® or receiving injections of ABILIFY MAINTENA®:
  - ☐ Compulsive gambling
  - ☐ Hypersexuality
  - ☐ Binge eating
  - ☐ Compulsive or Uncontrollable shopping
- ☐ The Class Member took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **1-6 months <u>and</u>** while on or within 3 months of discontinuing their use of ABILIFY® and/or receiving injections of ABILIFY MAINTENA®, experienced one or more of the following Compulsive Behaviours or Impulse Control Disorders of such severity that treatment or counselling was sought for the Compulsive Behaviours or Impulse Control Disorders in question (check all that apply):
  - ☐ Gambling counselling
  - ☐ Hypersexuality clinic
  - ☐ Binge eating clinic
  - ☐ Uncontrollable shopping clinic

SEVERE:

☐ The Class Member took ABILIFY® and/or received injections of ABILIFY MAINTENA® for **more than 6 months <u>and</u>** experienced one or more of the below Compulsive Behaviours or Impulse Control Disorders while on or within 3 months of discontinuing their use of ABILIFY® and/or receiving injections of ABILIFY MAINTENA® (check all that apply):

- ☐ Compulsive gambling
- ☐ Hypersexuality
- ☐ Binge eating
- ☐ Uncontrollable shopping

AND

☐ The Class Member experienced bankruptcy, divorce, re-mortgaging of a property, and/or criminal prosecution for fraud, theft, etc. contemporaneous to or after experiencing Compulsive Behaviours and/or Impulse Control Disorders, check all that apply:

- ☐ Declaration of Bankruptcy
- ☐ Divorce
- ☐ Re-mortgaging a property
- ☐ Criminal prosecution
- ☐ Other _____

OR/AND (if applicable)

☐ While on or within 3 months of discontinuing their use of ABILIFY® or receiving injections of ABILIFY MAINTENA®, The Class Member experienced one or more of the following Compulsive Behaviours or Impulse Control Disorders **for more than 6 months** of such severity that treatment or counselling was sought for the Compulsive Behaviours or Impulse Control Disorders in question **for more than 6 months** (check all that apply):

- ☐ Compulsive gambling
- ☐ Hypersexuality

☐ Binge eating

☐ Uncontrollable shopping

Attestation

The undersigned attests, under penalty of law, that the information provided in this Claim Form is true and correct to the best of his/her knowledge, information and belief.

_____ Date: _____

Signature of Class Member or their Representative DD/MM/YYYY

Section 8 –Financial Loss

This section <u>only</u> applies if you are submitting a claim for a Class Member's alleged financial loss. A total of $1.7 million dollars has been set aside to compensate eligible Class Members for their financial losses, and will be distributed *pro rata* among Class Members who submit claims with priority given to those who submit documentation in support of their claims relating to gambling losses.

If you are claiming compensation for financial harm relating to compensable gambling losses or a loan relating to gambling losses, please complete this section and attach the requested Gambling Records and Financial Records.

1) Compensable gambling losses

☐ Please attach **all available** Gambling Records for all venues at which gambling took place. This documentation must show the gambling activities at each venue. Gambling venues include casinos, online gambling websites, and any other venue in which the at issue gambling occurred whether in person or virtually. Supportive documentation may include, but is not limited to, records of gambling counselling, ATM withdrawal at casinos, credit card or banking statements showing payments for gambling, together with a signed attestation by the Class Member or their legal representative, available at **Section 8A,** of the net amount of any gambling losses.

☐ Please indicate if the Class Member was taking any other prescription medications with dopamine agonist properties while the at issue gambling occurred. Such medications include, but are not limited to, the following (please check all that you were taking when the at issue gambling occurred):

- ☐ Pramipexole (Mirapex)
- ☐ Ropinirole (Requip)
- ☐ Pergolide (Permax)
- ☐ Other (please fill in): _____

2) Compensable income loss

☐ Please attach

i) documentation to demonstrate that the Class Member experienced the Compulsive Behaviours (gambling records, such as ATM withdrawals at casinos, self-exclusion from a casino, credit card or banking statements showing payments for gambling, or medical records or counselling records documenting that treatment was sought for Compulsive Behaviours, together with a signed attestation that you

experienced the Compulsive Behaviours);

and

ii) records of any income loss if your Compulsive Behaviours or Impulse Control Disorders resulted in termination or loss of employment, including: the applicable employment agreement and income tax returns for the two years preceding the termination. Please also submit the Class Member Attestation **and/or** the Employer's Attestation available below under **Section 8B**, describing the reason for termination of employment.

3) Compensable loan losses

☐ Please attach:

i) documentation to demonstrate that the Class Member experienced the Compulsive Behaviours (gambling records, such as ATM withdrawals at casinos, self-exclusion from a casino, credit card or banking statements showing payments for gambling, or medical records or counselling records documenting that treatment was sought for Compulsive Behaviours, together with a signed attestation that you experienced the Compulsive Behaviours);

and

ii) all available financial records related to any loan for which compensation is sought. If the loan is from a financial institution, this must include a current statement of account for the loan. If the loan is from a private lender, friend, or family member, please provide an attestation from the lender, under penalty of law, confirming: the balance of the loan outstanding, the loan principal, accrued interest to date, and an account of all payments toward the loan received to date.

Section 8A – Class Member's Attestation Regarding Gambling Losses

Attestation

The undersigned attests, under penalty of law, that the Class Member

a) Took ABILIFY® and/or received injections of ABILIFY MAINTENA® and experienced Compulsive Gambling while on or within 3 months of discontinuing their use of ABILIFY® or receiving injections of ABILIFY MAINTENA®;

AND

b) Suffered gambling losses in the net amount of approximately _____.

_____ Date: _____

Signature of Class Member or their Representative

DD/MM/YYY

Section 8B – Compensable Income Loss

This section <u>only</u> applies if you are submitting a claim for a Class Member's compensable income loss.

If you are claiming compensation for a Class Member's income loss if their Compulsive Behaviours or Impulse Control Disorders resulted in their termination or loss of employment, please complete the Class Member and/or the Employer's Attestation below and attach the requested documents.

i) attach **complete** records of any income loss if the Class Member's Compulsive Behaviours or Impulse Control Disorders resulted in termination or loss of employment, including: the applicable employment agreement and income tax returns for the two years preceding the termination;

AND

ii) have the Class Member and/or the Class Member's Representative fill out the attestation below confirming termination of employment and the reason for termination, **<u>or</u>** provide the Employer's Attestation.

CLASS MEMBER'S ATTESATION

Information About Employer

Business Name: _____

Address: _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Phone ---------- _____ E-mail _____

Information About Class Members' Employment

Duration (Dates) of Class Member's Employment _____

Description of Class Member's Job Duties and Renumeration: _____

_____

_____

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_____

Date of Termination: _____

Reason(s) for Termination:

_____

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Attestation

The undersigned attests, under penalty of law, that the Class Member's Compulsive Behaviours or Impulse Control Disorders and resulting behaviour was the cause of their termination.

_____ Date: _____

Signature of Class Member or their Representative DD/MM/YYYY

EMPLOYER'S ATTESATION

Should the Class Member elect to submit the Employer Attestation, and if the Class Member experienced termination or loss of employment by more than one employer, this section should be completed separately by each employer.

Information About Employer

Last Name:_____First Name_____

Business Name: _____

Relationship to Class Member:_____

Address:_____P.O. Box_____

City_____Province_____Postal Code_____

Phone ---------- _____E-mail _____

Information About Class Members' Employment

Duration (Dates) of Class Member's Employment _____

Description of Class Member's Job Duties and Renumeration:_____

_____

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_____

Date of Termination: _____

Reason(s) for Termination:

_____

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_____

Attestation

The undersigned attests, under penalty of law, that that the information provided in this Attestation is true and correct to the best of their knowledge, information and belief.

_____ Date: _____

Signature of Employer DD/MM/YYYY

Section 9 – Class Member Declaration

This Section is to be completed by the Class Member, the Representative of the Class Member or the Legal Representative of the Class Member.

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 an official Court document approved by the Ontario and Québec Courts that preside over the Settlement, and submitting this Claim Form to the Claims Administrator 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 law that the information provided in this Claim Form is true and correct to the best of his/her knowledge, information and belief.

_____ Date _____

Signature DD/MM/YYYY

Section 10 –Physician Declaration

This Section is to be completed ONLY if you were UNABLE to obtain and provide the prescription records and/or medical records 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 attest that the Class Member was prescribed and/or provided with ABILIFY® and or ABILIFY MAINTENA® as follows:

   ABILIFY® ☐ YES ☐ NO
   Date(s), duration and dosage(s):_____
   _____
   _____

   ABILIFY MAINTENA® ☐ YES ☐ NO
   Date(s), duration and dosage(s):_____
   _____
   _____

Signature of Physician_____Date_____

Name of Physician_____

CPSO# (or equivalent)_____

Address: _____

_____

Telephone Number: _____

Section 11 – Class Member Declaration – Missing Product Identification Documentation

This Section is to be completed ONLY if you were UNABLE to obtain and provide the prescription records and/or medical records required by Section 6 above.

The undersigned hereby declares under penalty of law that the Class Member was prescribed and/or provided with ABILIFY® and/or ABILIFY MAINTENA® as follows:

ABILIFY® □ YES □ NO
Date(s), duration and dosage(s):

_____
_____
_____

ABILIFY MAINTENA® □ YES □ NO
Date(s), duration and dosage(s):

_____
_____
_____

The undersigned attests that reasonable best efforts were made to obtain the required medical records and/or prescription records and the following are the reasons WHY such documentation could not be obtained and provided (please attach additional sheets if needed):

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_____ Date _____

Signature of Class Member or their Representative DD/MM/YYY