

## NORTH BATTLEFORD CRYPTOSPORIDIUM CLASS ACTION SETTLEMENT

### INFANT CLASS CLAIM FORM

**TO BE ELIGIBLE FOR COMPENSATION YOUR COMPLETED CLAIM FORM TOGETHER WITH YOUR SWORN AFFIDAVIT AND OTHER SUPPORTING DOCUMENTATION MUST BE MAILED TO THE ADMINISTRATOR NO LATER THAN NOVEMBER 25, 2017.**

**A SEPARATE CLAIMS FORM, SWORN AFFIDAVIT AND SUPPORTING DOCUMENTATION MUST BE COMPLETED AND SUBMITTED FOR EACH PERSON CLAIMING COMPENSATION**

#### INSTRUCTIONS FOR CLAIM FORM

1. To be eligible to receive compensation through this settlement you or the person you are completing this form on behalf of must:
  - i) Have contracted Cryptosporidiosis or symptoms of Cryptosporidiosis as a result of consuming water supplied by the City of North Battleford between March 20 and April 25, 2001;
  - ii) Been under the age of 18 as of the time you contracted Cryptosporidiosis or symptoms of Cryptosporidiosis;
  - iii) Not have Opted Out of the Settlement; and
  - iv) Have not received compensation through any previous settlement related to the 2001 Cryptosporidium outbreak in North Battleford, Saskatchewan.
2. You must fill out each section of this Claim Form in its entirety unless otherwise directed in the Claim Form.
3. You must provide all of the required documentation stipulated in this Claim Form and listed in the Compensation Grid for the specific category pursuant to which you are claiming compensation.
4. Claim Forms, along with sworn affidavits and supporting documentation must be sent by mail to the Administrator postmarked no later than **November 25, 2017**. The Administrator's address is:

**The Court appointed Claims Administrator - Bruneau Group Inc.**

Attention: NB Water Class Action Settlement  
Nelson P.O. 20187 – 322 Rideau Street  
Ottawa Ontario K1N 5Y5  
Toll Free Tel: 1-855-745-7334  
Toll Free Fax: 1-866-262-0816  
Email: [info@northbattlefordwaterclaim.ca](mailto:info@northbattlefordwaterclaim.ca)

5. Class Counsel is prepared to assist you with completing your claims form and affidavit along with obtaining your supporting documentation (if available). However, if you want Class Counsel to assist you with your claims form and/or in retrieving your supporting medical documentation you must contact Class Counsel as soon as possible. If you have questions about this form you can contact either the Administrator or Class Counsel.
6. The Administrator may be reached by telephone at (855) 745-7334 or by email at [info@northbattlefordwaterclaim.ca](mailto:info@northbattlefordwaterclaim.ca)
7. Class Counsel may be reached by telephone at (306) 477-7247 or by email at [northbattleford@cuelenaere.com](mailto:northbattleford@cuelenaere.com)

**1. IDENTIFICATION OF CLASS MEMBER**

Name: \_\_\_\_\_  
Legal Name of Class Member

**If Class member is currently under the age of 18, provide the name or parent or guardian:**

Name: \_\_\_\_\_  
Legal Name of Parent of Guardian

Date of Birth of Class Member: \_\_\_\_\_  
(Month/Day/Year)

Current Address: \_\_\_\_\_  
No./Apt./Street City Province Postal Code

Phone: \_\_\_\_\_  
(Home) (Work) (Cell)

E-Mail: \_\_\_\_\_

**2. INFORMATION OF THE CLASS MEMBER**

Did the Class Member live in North Battleford or Battleford between March 20 and April 25, 2001?

\_\_\_\_\_ Yes or \_\_\_\_\_ No

If No, in what city or town did the Class Member live between March 20 and April 25, 2001?

\_\_\_\_\_

If the Class Member did not live in North Battleford between March 20 and April 25, 2001 what was your reason for being in North Battleford during this time period?

\_\_\_\_\_

Has the Class Member received payment from any of the previous settlements resulting from the 2001 Cryptosporidiosis water contamination in the City of North Battleford?

\_\_\_\_\_ Yes    or    \_\_\_\_\_ No

**3. ILLNESS INFORMATION**

Did the Class Member consume drinking water supplied by the City of North Battleford between March 20 and April 25, 2001?

\_\_\_\_\_ Yes    or    \_\_\_\_\_ No

On or about what day did the Class Member become ill with the symptoms of cryptosporidiosis?

\_\_\_\_\_

What symptoms of cryptosporidiosis did the Class Member have?

\_\_\_\_\_

For how many days was the Class Member ill with the symptoms of cryptosporidiosis?

\_\_\_\_\_

Did the Class Member see a Doctor because of the illness?

\_\_\_\_\_ Yes    or    \_\_\_\_\_ No

**If the Class Member did not consult a Doctor please proceed to section 4 of this form**

If the Class Member saw a Doctor, list the Doctor(s) and/or Hospital(s) the Class Member attended:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was the Class Member hospitalized due to the symptoms of cryptosporidiosis?

\_\_\_\_\_ Yes or \_\_\_\_\_ No

If the Class Member was hospitalized, for how many days?

\_\_\_\_\_ Did the Class Member receive a medical diagnosis of cryptosporidiosis?

\_\_\_\_\_ Yes or \_\_\_\_\_ No

**IF THE CLASS MEMBER SAW A DOCTOR IN REGARDS TO THEIR ILLNESS THE CLASS MEMBER MUST PROVIDE A COPY OF THEIR MEDICAL RECORDS SUPPORTING THIS CLAIM. OTHERWISE THE CLASS MEMBER WILL BE DEEMED TO BE A CATEGORY 1 CLAIMANT NO MATTER HOW MANY DAYS THEY WERE ILL.**

**IF YOU REQUIRE ASSISTANCE IN OBTAINING THE CLASS MEMBER'S MEDICAL RECORDS OR DETERMINING THE DOCTOR(S) OR HOSPITAL(S) THE CLASS MEMBER ATTENDED AT, CONTACT CLASS COUNSEL IMMEDIATELY AND PROVIDE THEM WITH THIS CLAIM FORM AND AUTHORIZATIONS WHICH WILL BE MAILED TO YOU BY REQUEST OR FOUND ON THEIR WEBISTE [www.cuelenaere.com/northbattleford](http://www.cuelenaere.com/northbattleford)**

<b>4. REQUIRED DOCUMENTATION</b>
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I hereby enclose the following documents in support of my claim (please place a checkmark beside all that apply):

\_\_\_\_\_ Birth Certificate

\_\_\_\_\_ Sworn Affidavit in accordance with the Compensation Grid. **THE REQUIRED AFFIDAVIT MUST BE SUBMITTED ALONG WITH THIS CLAIM FORM**

\_\_\_\_\_ Copy of my medical records

\_\_\_\_\_ Signed Authorizations to allow Class Counsel to attempt to obtain my medical records that Class Counsel will then submit (if they exist and have been located) to the Administrator along with this Claim Form.

**\* The Defendants will only be reimbursing the costs of obtaining medical records of approved claims. If your claim was rejected you will be responsible to pay the costs of obtaining the medical records.**

**5. DECLARATION**

I declare that I have read and understand the contents of this Claim Form. I declare under penalty of perjury that the statements I have made in this Claim Form are true, correct and complete to the best of my knowledge, information and belief,

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Claimant or Representative

**NOTE:** To preserve the Class Member's eligibility for payment pursuant to the Settlement Agreement, this Claim Form, together with your Sworn Affidavit and the required supporting documentation for the specific category you are claiming compensation under must be postmarked (if sent by mail) to the Administrator or received by the Administrator (if by email or fax) no later than November 25, 2017

**Please mail, fax or email this Claim Form, your Sworn Affidavit and Supporting Documentation to the Administrator at the address listed below:**

**The Court appointed Claims Administrator - Bruneau Group Inc.**  
Attention: NB Water Class Action Settlement  
Nelson P.O. 20187 – 322 Rideau Street  
Ottawa Ontario K1N 5Y5

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