

TVQ Class Action
c/o RicePoint Administration Inc.
P.O. Box 3355
London, Ontario
N6A 4K3



TVQ

BOSTON SCIENTIFIC TRANSVAGINAL MESH CLASS ACTION

**Must Be Postmarked
No Later Than
January 18, 2023**

Claim Form - Supplemental Claim Period

**BOSTON SCIENTIFIC (BSC) TRANSVAGINAL MESH CLASS
ACTION SETTLEMENT INSTRUCTIONS FOR CLAIMANTS**

Boston Scientific (BSC) Transvaginal Mesh Devices are used to treat either stress urinary incontinence (“SUI”) or pelvic organ prolapse (“POP”). To be eligible to make a claim in the Supplemental Claims Period, you must be resident in Canada and implanted with a BSC Transvaginal Mesh Device on or before February 28, 2020.

For the purposes of this Claim Form, “BSC Transvaginal Mesh Device” means any of the products listed below. If you have more than one of the below listed products, you may claim in respect of each one.

BSC Transvaginal Mesh Device(s): means

- * Advantage System (including, but not limited to, Advantage Fit System),
- * Obtryx Transobturator Mid-Urethral Sling,
- * Obtryx II,
- * Lynx Suprapubic Mid-Urethral Sling System,
- * Solyx Single Incision Sling (SIS),
- * Pinnacle Pelvic Floor Repair Kit, anterior/apical and posterior configuration, and
- * Uphold Vaginal Support System.

THE DEADLINE TO SUBMIT A CLAIM IS JANUARY 18, 2023.



FOR CLAIMS PROCESSING ONLY	OB <input type="checkbox"/>	CB <input type="checkbox"/>	<input type="radio"/> DOC <input type="radio"/> LC <input type="radio"/> REV	<input type="radio"/> RED <input type="radio"/> A <input type="radio"/> B
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Claim Forms can be submitted to the Claims Administrator online at www.canadabscmeshclassaction.com. For claims submitted in paper form, Claim Forms must be postmarked on or before January 18, 2023 and mailed to the following address:

TVQ Class Action
c/o RicePoint Administration Inc.
P.O. Box 3355
London, Ontario
N6A 4K3

If you require assistance or advice regarding completion of the Claim Form, you may retain legal counsel at your own expense or contact the Claims Administrator, free of charge, at 1-866-795-5067. **Claimants who retain lawyers or agents in completing their Claim Form shall be solely responsible for the fees and expenses of such lawyers or agents.**

Claimants (or their lawyers/agents) **must** advise the Claims Administrator **in writing** of any changes or corrections in name, address, phone number, or legal representation.

Please keep copies of all documentation you send to the Claims Administrator.

Please note that it could take several weeks or longer to obtain the required supporting medical documentation to support your claim. Please start completing the claims process now.

If you are claiming on behalf of an Estate or a person with a disability, you must provide all supporting documents that authorize you to represent the Estate or person under disability.

PRIVACY STATEMENT

Personal Information regarding Claimants 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 American Medical Systems Women’s Pelvic Mesh Settlement (“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 and Compensation Protocol.



BSC TRANSVAGINAL MESH CLASS ACTION SETTLEMENT CLAIM FORM

SECTION 1—Claimant Identification

I am applying on behalf of the following Claimant:

- 1. Myself**
- 2. Claimant A or B:**
 - A. A person under legal disability**
Please enclose a copy of your authority to act (i.e. power of attorney, etc.)
 - B. Deceased**
Please enclose a copy of your authority to act (i.e. will, court order, etc.)

If you submitted a claim in the Initial Claims period, please provide your claim ID.

TVQ-

Please complete this Section with the information of the Claimant who is over the age of 18. If you are applying on behalf of an individual under a disability or an Estate, but not yourself, please also complete Section 2. If you are a lawyer or agent who is completing this form on behalf of your client, please complete this Section and Section 3.

<input type="text"/>	<input type="text"/>	<input type="text"/>
Claimant's First Name	M.I.	Last Name
<input type="text"/>		
Address		
<input type="text"/>	<input type="text"/>	<input type="text"/>
City	Province	Postal Code
<input type="text"/> — <input type="text"/> — <input type="text"/>	<input type="text"/> — <input type="text"/> — <input type="text"/>	
Home Phone	Work Phone	
<input type="text"/>		
Email		
<input type="text"/>		
Provincial Health Card Number		
<input type="text"/>	<input type="text"/>	<input type="text"/>
MM / DD / YYYY		
Date of Birth		
<input type="text"/>	<input type="text"/>	<input type="text"/>
MM / DD / YYYY		
For Estate Claims: Date of Death		

***Please attach the official death certificate.**



SECTION 2—Representative Identification

*This section is to be completed **only** if you are submitting a claim as the Representative of an individual under legal disability or an Estate. You **MUST** provide proof of your authority to act as the Representative of an individual under legal disability or an Estate.*

Representative's First Name										M.I.		Last Name											
Address																							
City										Province				Postal Code									
Home Phone						—		—				Work Phone		—		—							
Email																							
Specify proof of authority to represent provided:																							

SECTION 3—Legal Representative Identification

*This Section is to be completed only if a lawyer or agent is representing the Claimant, Estate Representative or Representative of an individual under legal disability. If you complete this section, all correspondence will be sent to your legal representative. **If you complete this section, you MUST complete Schedule "A"**.*

Name of Law Firm or Agency																					
Lawyer's or Agent's First Name										M.I.		Last Name									
Address																					
City										Province				Postal Code							
Phone						—		—													
Email																					



SECTION 4—Initial Implant Supporting Information

Please complete the chart below for each BSC Transvaginal Mesh Device implanted. **Do NOT include information on mesh products manufactured by other companies.**

Implant #1	
Implant Name/Model	
Date of Implant	
Pre-Operative Diagnosis	
Post-Operative Diagnosis	
Operative Procedure Performed	
Facility/Physician	

Implant #2	
Implant Name/Model	
Date of Implant	
Pre-Operative Diagnosis	
Post-Operative Diagnosis	
Operative Procedure Performed	
Facility/Physician	

Implant #3	
Implant Name/Model	
Date of Implant	
Pre-Operative Diagnosis	
Post-Operative Diagnosis	
Operative Procedure Performed	
Facility/Physician	

Implant #4	
Implant Name/Model	
Date of Implant	
Pre-Operative Diagnosis	
Post-Operative Diagnosis	
Operative Procedure Performed	
Facility/Physician	



Note: See Page 1 for a list of eligible BSC Transvaginal Mesh Devices. To be eligible for compensation under this Settlement, for EACH BSC Transvaginal Mesh Device implanted, you **MUST** provide:

- A copy of the product identification sticker(s) (PID)

OR if a copy or copies of the PID is/are not available and the implant is a BSC Transvaginal Mesh Device, *you must submit one or more of the other forms of evidence below:*

- Medical records contemporaneous to the implantation procedure for the BSC Transvaginal Mesh Device recording the product identification information (product numbers) from the product identification sticker, tag, or label;
- Medical records contemporaneous to the implantation procedure for the BSC Transvaginal Mesh Device identifying the information of the model of the BSC Transvaginal Mesh Device;
- Documentation from the implanting surgeon providing confirmation of the model of the BSC Transvaginal Mesh Device OR other confirmation that the implanted device was a BSC Transvaginal Mesh Device; or
- Documentation from the implanting hospital purchasing department providing confirmation of the model of the BSC Transvaginal Mesh Device OR other confirmation that the implanted device was a BSC Transvaginal Mesh Device.

For implanted mesh products made by ANOTHER manufacturer, please provide product documentation if you have it.

SECTION 5—Qualifying Treatment and Supporting Surgical or Treatment Evidence

Please check all that apply and provide the required medical evidence. Note: medical records supporting each category are required to be eligible for compensation.

Treatment	Supporting Treatment Evidence	Approximate Date(s) of Treatment
<p>Please indicate all treatments <u>below which were performed AFTER implantation of your BSC Transvaginal Mesh Device</u> that are attributed by your treating medical provider to your complications/symptoms from the implantation of your BSC Transvaginal Mesh Device.</p>	<p>For the purposes of this Claim Form, “Surgical or Treatment Evidence” means proof, by way of contemporaneous medical records, which may include contemporaneous physician or hospital records supplemented by a letter from the physician providing any needed clarification of the contents of the records, of each claimed surgical intervention or treatment which is used to claim compensation.</p> <p><i>Please select all that apply and for which medical records are included with this claim.</i></p>	
<ul style="list-style-type: none"> ● Pain medications for treatment of pelvic pain. 	<ul style="list-style-type: none"> ● Medical evidence confirming a prescription for pain medication for treatment of pelvic pain commencing at least 90 days after implantation of a BSC Transvaginal Mesh Device and with continuous use for a period of at least two months is included and attached. <p><i>Note: Surgical Pain is a normal outcome of a surgical procedure and is not compensable under this Settlement.</i></p>	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>



Treatment	Supporting Treatment Evidence	Approximate Date(s) of Treatment
<ul style="list-style-type: none"> Physical therapy of pelvic floor and/or vaginal area. <p>Start Date: <input type="text"/></p> <p>Stop Date: <input type="text"/></p> <p>Number of Sessions: <input type="text"/></p>	<ul style="list-style-type: none"> Evidence of physical therapy of pelvic floor and/or vaginal area commencing at least 90 days after implantation of a BSC Transvaginal Mesh Device and involving at least 4 sessions over a 60-day period, is included and attached. 	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
<ul style="list-style-type: none"> Anesthetic block (e.g. epidural, spinal) for pain in or originating from the pelvic area. 	<ul style="list-style-type: none"> Medical evidence of anesthetic block (e.g. epidural, spinal) for pain in or originating from the pelvic area is included and attached. 	<hr/> <hr/>
<ul style="list-style-type: none"> Either of trigger point injection, local nerve block or nerve ablation in the pelvic area. 	<ul style="list-style-type: none"> Medical evidence of trigger point injection and/or local nerve block and/or nerve ablation in the pelvic area is included and attached. 	<hr/> <hr/>
<ul style="list-style-type: none"> Botox injection(s) into pelvic muscles 	<ul style="list-style-type: none"> Medical evidence of Botox injection(s) into the pelvic muscle is included and attached. 	<hr/> <hr/>
<ul style="list-style-type: none"> Revision and/or trim of a BSC Transvaginal Mesh Device under topical or local anesthetic. 	<ul style="list-style-type: none"> Medical evidence of revision and/or trim of a BSC Transvaginal Mesh Device under topical or local anesthetic is included and attached. 	<hr/> <hr/>
<ul style="list-style-type: none"> Drainage of sinus tract or abscess occurring within the vicinity of site implant or insertion tract. 	<ul style="list-style-type: none"> Medical evidence of drainage of sinus tract or abscess occurring within the vicinity of the site of implantation or the insertion tract of a BSC Transvaginal Mesh Device, and which was performed at least 30 days after the implantation of a BSC Transvaginal Mesh Device, is included and attached. 	<hr/> <hr/> <hr/> <hr/>
<ul style="list-style-type: none"> 3 or more bacterial infections (vaginal or urinary tract) treated with antibiotics. 	<ul style="list-style-type: none"> Medical evidence of 3 or more bacterial infections (vaginal or urinary tract) treated with antibiotics at least 30 days after the implantation of a BSC Transvaginal Mesh Device, is included and attached. 	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>



Treatment	Supporting Treatment Evidence	Approximate Date(s) of Treatment
<ul style="list-style-type: none"> Other non-surgical mesh related treatments or new-onset mesh-related conditions (i.e. fistula, and organ (i.e. bladder or bowel perforation)) <p>Describe:</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>	<ul style="list-style-type: none"> Medical evidence of other non-surgical mesh-related treatments or new-onset mesh-related conditions (i.e. fistula, and organ (i.e. bladder or bowel) perforation) is included and attached. <p>Note: Non-Surgical treatments do not include diagnostic cystoscopies, MRI or ultrasound procedures without evidence of new-onset mesh-related conditions.</p>	<hr/> <hr/>

Qualifying Surgery	Supporting Surgical Evidence	Approximate Date(s) of Surgery
Defined as a Surgical Procedure performed under General Anesthesia or Regional Anesthesia to:	Please complete all boxes for which Surgical Treatment Evidence is provided with this Claim Form. Operative Reports and Medical Records are required for each procedure claimed.	
<ul style="list-style-type: none"> Remove all or a portion of a BSC Transvaginal Mesh Device. 	<ul style="list-style-type: none"> Surgical records confirming removal of all or a portion of a BSC Transvaginal Mesh Device are included and attached. 	<hr/> <hr/> <hr/> <hr/>
<ul style="list-style-type: none"> Release the arms of a BSC Transvaginal Mesh Device. 	<ul style="list-style-type: none"> Surgical records confirming release of the arms of a BSC Transvaginal Mesh Device are included and attached. 	<hr/> <hr/> <hr/> <hr/>



Qualifying Surgery	Supporting Surgical Evidence	Approximate Date(s) of Surgery
<ul style="list-style-type: none"> Excise or lyse scar tissue or scar bands at the site of implant of a BSC Transvaginal Mesh Device. 	<ul style="list-style-type: none"> Surgical records confirming excise or lyse scar tissue or scar bands at site of implant of a BSC Transvaginal Mesh Device are included and attached. 	<hr/> <hr/> <hr/> <hr/>
<ul style="list-style-type: none"> Explore the cause of a condition or symptom suspected by the treating medical provider(s) in the contemporaneous medical records to be caused by the implantation of a BSC Transvaginal Mesh Device, which is performed via an open or laparoscopic approach, and for which the operative records do not reflect that another cause of the condition or symptom (e.g. ovarian cyst, endometriosis) was determined as the cause during surgery. 	<ul style="list-style-type: none"> Surgical records confirming the exploration of the cause of a condition or symptom to be caused by the implantation of a BSC Transvaginal Mesh Device, which is performed via an open or laparoscopic approach, and for which the operative records do not reflect that another cause of the condition or symptom (e.g. ovarian cyst, endometriosis) was determined as the cause during surgery, are included and attached. 	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>

SECTION 6—Release of Claims

I verify that I have / have not received compensation through other proceedings or private out-of-class settlements and/or provided a release in respect of a BSC Transvaginal Mesh Device.

If you have received compensation or released claims, please provide the details here:

Compensation: \$

Details of Claims Released:



SECTION 7—Claimant Declaration and Authorization

The undersigned hereby consents 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 sanctioned by the Court that presides over the Settlement, and submitting this Claim Form to the Claims Administrator is equivalent to filing it with a Court.

The undersigned hereby authorizes the Claims Administrator to contact the Claimant as required in order to administer the claim.

I verify that I am at least 18 years old.

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.

Claimant’s Signature (or Claimant’s Representative): _____

Printed Name of Claimant (or Claimant’s Representative): _____

Dated (mm/dd/yyyy): _____

PLEASE ATTACH AND SUBMIT ALL REQUIRED SUPPORTING EVIDENCE WITH YOUR CLAIM

Reminder Checklist:

1. Complete the relevant sections and sign the Claimant Declaration and Authorization.
2. If the Claim is being submitted by a third party (lawyer or agent), please complete, sign and have Schedule “A” witnessed (anyone over the age of 18 can witness).
3. Keep a copy of your Claim Form and all supporting documentation for your records.
4. If you move, please send the Claims Administrator your new address. Failure to notify the Claims Administrator of a new address may result in your Settlement benefits not being paid to you.



Schedule "A"

CLAIMS FILED BY A LEGAL REPRESENTATIVE ON BEHALF OF THE SETTLEMENT CLASS MEMBER

This Schedule is to be completed **only** if the Claim is being submitted by a third party on behalf of the Claimant.

I, _____ [*name of Claimant, Estate Representative or Representative of an individual under legal disability*] authorize _____

[*name of Legal Representative (Lawyer or Agent)*] to file a Claim Form in the BSC Transvaginal Mesh Class Action on my behalf and to receive all communication relevant to my claim (including the cheque, if eligible for payment).

DATED at _____ [*name of city*], in the Province of _____,

in the Country of _____ this _____ day of _____, 20__.

Individual Claimant, Estate Representative OR Representative of an individual under legal disability:

Signature: _____

Witness Signature: _____

Witness Print Name: _____



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