Must be Postmarked
No Later Than
July 17, 2017

FOSAMAX/FOSAVANCE CLASS ACTION
CANADA-WIDE SETTLEMENT AGREEMENT

PRODUCT USER CLAIM FORM

Private & Confidential

(Please type or use blue or black pen and write legibly)

THIS PRODUCT USER CLAIM FORM SHOULD BE COMPLETED BY OR ON BEHALF OF THE PRODUCT USER; IN OTHER WORDS, THE PERSON WHO ALLEGEDLY USED FOSAMAX OR FOSAVANCE. THIS FORM SHOULD NOT BE USED BY ANY SPOUSE OR CHILD TO ASSERT A DERIVATIVE CLAIM.

CATEGORY OF CLAIM:

Please check off below the type of event(s) you claim resulted from use of Fosamax/ Fosavance. Note: You are only allowed to claim one atypical femur fracture per leg. Only the three types of events listed below are eligible for this program:

CHECK THE APPLICABLE BOX(ES)

ATYPICAL FEMUR FRACTURE (LEFT LEG) ☐

ATYPICAL FEMUR FRACTURE (RIGHT LEG) ☐

OSTEONECROSIS OF THE JAW ☐

Please read the following "Agreement and Instructions" and complete the Claim Form in full.

DEADLINE TO SUBMIT ALL CLAIM DOCUMENTATION: July 17, 2017

AGREEMENT AND INSTRUCTIONS

A. This is a "Product User Claim Form" referred to in the Class Action Canada-Wide Settlement Agreement dated April 10, 2015 relating to Fosamax and Fosavance (sometimes referred to as "alendronate") for the resolution in Canada, and with respect to all residents of Canada, of all Claims against, and all Liabilities of, the Merck Parties and the other Releasees Connected With Fosamax/Fosavance (the "Settlement Agreement"). Capitalized terms used but not defined in this Product User Claim Form shall have the respective meanings assigned to such terms in the Settlement Agreement, including in Annex A thereto. In the event of any conflict between any term of this Product User Claim Form and the terms of the Settlement Agreement, the terms of the Settlement Agreement shall prevail.

B. This Product User Claim Form is to be used for submitting an alleged personal injury claim and any lost income claim by or on behalf of any Product User. Only persons in Canada who were prescribed and ingested Fosamax and/or Fosavance, whether now living or deceased (other than any Excluded Person) can submit an alleged claim with respect to osteonecrosis of the jaw or an atypical femur fracture pursuant to the Settlement Agreement.

C. Please read this Product User Claim Form in its entirety and answer all inquiries on the Product User Claim Form itself (add additional sheets if necessary) and then sign and date the Product User Claim Form. **FAILURE TO FULLY ANSWER ALL INQUIRIES ON THE PRODUCT USER CLAIM FORM AND/OR SIGN THE PRODUCT USER CLAIM FORM WILL RESULT IN YOUR SUBMISSION BEING REJECTED. The foregoing notwithstanding, you must complete Part B of the Product User Claim Form only if you are claiming a Lost Income Award in addition to a Points-Based Award for personal injury, and your failure to complete Part B of the Product User Claim Form will not affect your application for a Points-Based Award. (The maximum Tentative Lost Income Grant that may be made to any particular Product User Claimant is capped at $54,000, and the aggregate amount of Lost Income Awards that may be made to all Product User Claimants is capped at $162,000.) However, you may not elect to complete only Part B of the Product User Claim Form; you must in all instances complete Parts A and C of the Product User Claim Form (and you cannot receive a Lost Income Award unless you are determined to be eligible to receive a Points-Based Award).**

D. **ON OR BEFORE JULY 17, 2017 YOU MUST SERVE** each of the following: (1) the completed and dated Product User Claim Form; (2) your medical, dental and pharmacy records (see Section 9 of Part A of the Product User Claim Form for a description of the medical, dental and pharmacy records requirements); and (3) the signed and dated Certificate of Service of Claim Form (with the appropriate box checked) attached to this Product User Claim Form. All of these materials are to be sent to the Claims Administrator at the following address:

Fosamax/Fosavance Class Action
RicePoint Administration
PO Box 3355
London, Ontario, Canada
N6A 4K3

E. **This Product User Claim Form, fully completed and properly signed, and all requisite medical, dental or pharmacy records and other documentation, must be submitted (as proven by either the post-mark date (if standard lettermail service is used) or the date received by the Claims Administrator (where same-day or overnight courier service is used) or the date the submission is capable of being accessed from the Claims Administrator's online repository (at www.fosamaxclassaction.ca) no later than July 17, 2017. FAILURE TO SUBMIT THESE MATERIALS ACCORDINGLY BY THE DEADLINE WILL RESULT IN YOUR CLAIM BEING REJECTED.**

F. Each Product User Claimant is required to provide the full names, relationship to the alleged Product User, date of birth and address of all spouses, common law spouses and/or children who may claim a separate award based upon any Points-Based Award made to the Product User Claimant, in Section 2 of Part A of the Product User Claim Form. (Each such related person separately must submit a Derivative Claimant Claim Form in accordance with the Settlement Agreement in order to claim a separate award based upon any such award, but such submission is not the responsibility of the Product User Claimant.)

G. To the extent that the person submitting this Product User Claim Form on behalf of a Product User Claimant is representing a minor, an incapable person, a person under a disability or the estate of a deceased person, such representative must represent and warrant that he or she is duly authorized as the proper representative to submit the claim and provide proof of same. It is the sole responsibility of the person submitting a claim to take the necessary steps to be appointed as the proper representative by court order, if the applicable law so requires. Additionally, all such persons must comply with all provisions of the Settlement Agreement. If your properly approved representative is required to report any award to any court, the amount of such award shall be maintained in the strictest confidence and all papers shall be filed under seal and all hearings held in private to the extent allowable under the applicable law. Drafts of all such court papers must be approved by the Merck Parties before filing with the court.

H. The signatories to the Product User Claim Form, the law firms with which they are affiliated (if any) and the Product User Claimant identified herein specifically agree to maintain the confidentiality of any awards of compensation that might result from the Settlement Agreement.

I. Notice: The submission of a Product User Claim Form and/or any other documentation to the Claims Administrator, the Merck Parties, Class Counsel or anyone else does not mean that the Product User Claimant will receive any payment under the Settlement Agreement. There are strict eligibility criteria which have been approved by the Courts that a Product User Claimant must first satisfy in order to be entitled to payment under the Settlement Agreement.

J. Notice: You understand and agree, as evidenced by your signature below, that you are solely responsible for the complete and final satisfaction of any and all Liens (e.g., by a social assistance provider) that are attached or may become attached at a later date to any award or payment that you may receive under the Settlement Agreement.

PRODUCT USER CLAIM FORM

UNLESS NOTED OTHERWISE, YOU MUST ANSWER ALL OF THE FOLLOWING QUESTIONS ON THIS FORM AND, IF NECESSARY, ATTACH ADDITIONAL SHEETS

(Please type or use blue or black pen and write legibly)

1. Demographic Information Regarding Alleged Fosamax and/or Fosavance User:

a. Merck-branded product used (e.g., Fosamax or Fosavance):

_____

b. Current name and other names (e.g., maiden names, married names) used by the alleged Product User for the ten years prior to the alleged Product User's alleged adverse event:

Prefix: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr.

_____ First Name _____ Middle Name _____ Last Name

_____ Prior Last Name

c. Alleged Product User's current or last known residence address:

_____ Street Address

_____ City _____ Province/Territory _____ Postal Code

( ) _____ Daytime Phone Number ( ) _____ Evening Phone Number _____ e-mail Address

d. If you are a resident of a province, territory or country other than as specified in 1.c above, please specify such other province, territory or country. (Note: If you leave the space below blank, you will be deemed to have been certified that you are a resident of the province or territory specified in 1.c above.):

_____ Province/Territory _____ Country

e. Alleged Product User's date of birth: _____ (Day/Month/Year)

f. Alleged Product User's health card number: _____

g. Language Preference: ☐ English ☐ French

2. Information about Spouse and/or Children

Information regarding any spouse (or former spouse) or child of the alleged Product User who may be entitled to submit a claim as derivative of the claim of the above-listed alleged Fosamax and/or Fosavance user. To be an Eligible Family Member, he or she must have been the spouse or child of the Product User at the time of the claimed atypical femur fracture and/or osteonecrosis of the jaw. Attach separate sheet(s) as necessary to answer all of the following questions for each such Eligible Family Member.

Note: Completion by the Product User Claimant of this Section does not relieve any related person listed therein from the requirement to submit a Derivative Claimant Claim Form; each such related person separately must submit a Derivative Claimant Claim Form in accordance with the Settlement Agreement in order to claim a separate award, but such submission is not the responsibility of the Product User Claimant.

Current name and other names (e.g., maiden names, married names) used by each Eligible Family Member and the nature of their relationship to the alleged Product User listed above:

Prefix: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr.

First Name _____ Middle Name _____ Last Name _____

Prior Last Name _____

Relationship to alleged Product User (i.e., spouse (or former spouse) or child) _____ Date of Birth (Day/Month/Year) _____

Period of spousal relationship to alleged Product User (if applicable) (specify dates): _____

Street Address _____

City _____ Province/Territory _____ Postal Code _____

( ) _____ ( ) _____ _____

Daytime Phone Number Evening Phone Number e-mail Address

Language Preference: English ☐ French ☐

3. Information about a Legal Representative (e.g. Executor of the Product User Claimant's Estate) (if applicable)

This Section is to be completed only if this claim is being made by a legal representative (e.g. guardian) on behalf of a Product User Claimant.

If you are completing this Product User Claim Form as a legal representative of the alleged Product User, please provide details about your relationship to the alleged Product User (e.g., as the executor for the estate of an alleged Product User) and if you are a court-appointed representative, please attach copies of the court orders making such appointment:

Type of legal representative (e.g. executor of estate, guardian): _____

Prefix: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Dr.

First Name	Middle Name	Last Name

Prior Last Name: _____

Relationship to alleged Product User (i.e., spouse (or former spouse) or child)	Date of Birth (Day/Month/Year)

Street Address: _____

City	Province/Territory	Postal Code

Daytime Phone Number	Evening Phone Number	e-mail address
( )	( )	

Language Preference: English ☐ French ☐

4. Legal Counsel Identification (if applicable)

This Section is to be completed only if a lawyer is representing the alleged Product User.

Law Firm Name: _____

Lawyer's Last Name	First Name	Middle Initial

Address

City | Province/Territory | Postal Code

( ) Phone | ( ) Fax | E-mail

Law Society Number

Language Preference: ☐ English ☐ French

Note: If you complete Section 4 (of this Part A) above, 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.

5. Facts Concerning Alleged Product User's Ingestion of Fosamax (note that facts related to alleged use of Fosavance and generic-branded alendronate are requested below):

a. Date Fosamax use started: _____

b. Date Fosamax use stopped: _____

c. Dose of Fosamax most often used: _____
([__], [__] or [__]mg)

d. Frequency of use of Fosamax:

Everyday: ☐
As needed: ☐
Other: ☐
If other, please specify: _____

e. Was the alleged Fosamax user taking Fosamax at the time of his/her Event?

YES ☐ NO ☐

f. List each healthcare provider who prescribed or provided Fosamax to the alleged Fosamax user. Please provide name(s), address and phone number:

g. List each pharmacy where Fosamax prescriptions were ever filled by or for the benefit of the alleged Fosamax user. Please provide name(s), address, and phone number:

h. Please provide a copy of complete Pharmacy Records for the entire period of time spanning the first alleged use of Fosamax, through the alleged Eligible Event (or, if more than one Eligible Event is alleged, through the date of the last such alleged Eligible Event).

Complete Pharmacy Records Attached ____ # pages OR

In the absence of pharmacy records please complete the chart below:

Name of Medication	Date(s) Used	Name and address of ordering healthcare provider

i. If samples of Fosamax were ever provided to the alleged Fosamax user, for each provision of samples, please provide the name, address, and phone number of the healthcare provider who provided samples, the date the samples were provided, and the specific number of Fosamax pills provided to the alleged Fosamax user.

Sample Provider	Date Samples Provided	Number of Samples Provided

6. Facts Concerning Alleged Product User's Ingestion of Fosavance (if any):

a. Date Fosavance use started: _____

b. Date Fosavance use stopped: _____

c. Dose of Fosavance most often used: _____
([__], [__] or [__]mg)

d. Frequency of use of Fosavance:

Everyday: ☐
As needed: ☐
Other: ☐
If other, please specify: _____

e. Was the alleged Fosavance user taking Fosavance at the time of his/her Event?

YES ☐ NO ☐

f. List each healthcare provider who prescribed or provided Fosavance to the alleged Fosavance user. Please provide name(s), address and phone number:

g. List each pharmacy where Fosavance prescriptions were ever filled by or for the benefit of the alleged Fosavance user. Please provide name(s), address, and phone number:

h. Please provide a copy of complete Pharmacy Records for the entire period of time spanning the first alleged use of Fosavance, through the alleged Eligible Event (or, if more than one Eligible Event is alleged, through the date of the last such alleged Eligible Event).

Complete Pharmacy Records Attached ____ # pages OR

In the absence of pharmacy records please complete the chart below:

Name of Medication	Date(s) Used	Name and address of ordering healthcare provider

i. If samples of Fosavance were ever provided to the alleged Fosavance user, for each provision of samples, please provide the name, address, and phone number of the healthcare provider who provided samples, the date the samples were provided, and the specific number of Fosavance pills provided to the alleged Fosavance user.

Sample Provider	Date Samples Provided	Number of Samples Provided

7. Facts Concerning Alleged Product User's Ingestion of generic-branded alendronate (if any) (attach additional sheets answering all of the following questions for each brand used, if necessary):

a. Name of generic alendronate used: _____

b. Date use of generic started: _____

c. Date generic use stopped: _____

d. Dose of generic most often used: _____
([__], [__] or [__]mg)

e. Frequency of use of generic:

Everyday: ☐
As needed: ☐
Other: ☐
If other, please specify: _____

f. Was the alleged Product User taking the generic at the time of his/her Event?
YES ☐ NO ☐

g. List each healthcare provider who prescribed or provided the generic alendronate identified in (a) above to the alleged Product User. Please provide name(s), address and phone number:

_____

_____

_____

_____

_____

h. Please provide a copy of complete Pharmacy Records for the entire period of time spanning the first alleged use of the generic alendronate identified in (a) above, through the alleged Eligible Event (or, if more than one Eligible Event is alleged, through the date of the last such alleged Eligible Event).

Complete Pharmacy Records Attached ☐ OR
pages

In the absence of pharmacy records please complete the chart below:

Name of Medication	Date(s) Used	Name and address of ordering healthcare provider

i. List each pharmacy where prescriptions for the generic alendronate identified in (a) above were ever filled by or for the benefit of the alleged Product User. Please provide name(s), address, and phone number:

_____

_____

_____

_____

_____

j. If samples of the generic alendronate identified in (a) above were ever provided to the alleged Product User, for each provision of samples, please provide the name, address, and phone number of the healthcare provider who provided samples, the date the samples were provided, and the specific number of pills of that generic alendronate provided to the alleged Product User.

Sample Provider	Date Samples Provided	Number of Samples Provided

8. Alleged Eligible Event(s):

Please provide the information requested below for your alleged Eligible Event(s). Only the three types of Eligible Events listed below will be considered under the Settlement Agreement. NOTE: You are only allowed to claim one atypical femur fracture per leg.

a. Alleged Eligible Event:

CHECK THE APPLICABLE BOX(ES)

Atypical Femur Fracture (left leg) ☐

Atypical Femur Fracture (right leg) ☐

Osteonecrosis of the Jaw ☐

b. Date of alleged Eligible Event: _____

(Day/Month/Year)

c. Where were you treated for your Eligible Event? Please provide name(s), address and phone number for each hospital, medical center or dental or other healthcare facility.

_____

_____

_____

_____

_____

d. ANSWER THIS QUESTION ONLY IF ALLEGED ELIGIBLE EVENT IS AN ATYPICAL FEMUR FRACTURE.

Who was the orthopedist, general practitioner or other doctor/physician or healthcare provider for the one (1) year period prior to the Eligible Event, and who treated you immediately following your alleged Eligible Event for the alleged injuries sustained during your Eligible Event?

NOTE: Please list all healthcare providers for the one (1) year prior to the alleged Eligible Event through six (6) months afterwards.

Please list name(s), address and phone number for each healthcare provider.

_____

_____

_____

_____

e. ANSWER THIS QUESTION ONLY IF THE ALLEGED ELIGIBLE EVENT IS OSTEONECROSIS OF THE JAW.

List the alleged Product User's primary care physician(s), dentist(s) or other dental or other healthcare providers for the one (1) year period prior to the Eligible Event and who treated you immediately following and through six (6) months after your alleged Eligible Event occurred.

NOTE: Please list all healthcare providers for the one (1) year prior to the alleged Eligible Event through six (6) months afterwards.

Please list name(s), address and phone number for each healthcare provider.

NOTE: If you allege more than one Eligible Event, you must provide the information requested in this Section 8 separately with respect to each such alleged Eligible Event. Use duplicate pages as necessary.

9. Medical, Dental and Pharmacy Records Requirements:

NOTE: FAILURE TO COMPLY WITH THE FOLLOWING RECORDS REQUIREMENTS WILL RESULT IN YOUR CLAIM NOT BEING ELIGIBLE FOR PAYMENT.

It is a strict requirement of the Settlement Agreement that all Product User Claimants produce true, complete, and correct copies of the PME Records, as detailed and described below. This is necessary for the Claims Administrator to properly evaluate whether a Product User Claimant satisfies the Eligibility Requirements and to perform a valuation of the claim of each Product User Claimant. Accordingly, the Claims Administrator is going to be closely reviewing the completeness of each Claims Package to ensure that a complete set of the required PME Records has been produced and that there is no evidence that any records have been withheld or in any way altered by the Product User Claimant or the Product User Claimant's counsel. Intentional withholding or alteration of records will be pursued in accordance with Section 4.6 of the Settlement Agreement with respect to fraudulent claims.

Definitions:

"Eligible Event" means osteonecrosis of the jaw or atypical femur fracture. Note: You are only allowed to claim one atypical femur fracture per leg. If a Product User Claimant has experienced multiple fractures in the same leg, he or she is required to specify in the Claims Package which fracture is to be the exclusive basis for the claim made with respect to that leg.

"Event Records" means:

(a) with respect to an alleged Eligible Event of osteonecrosis of the jaw ("ONJ"), (i) contemporaneous Medical Record containing a diagnosis of ONJ, or (ii) at least six (6) consecutive weeks of exposed bone, or (iii) at least eight (8) consecutive weeks of non-healing of an extraction socket or other oral dental surgical site; or

(b) with respect to an alleged Eligible Event of atypical femur fracture ("AFF"), (i) contemporaneous Medical Record containing a diagnosis of AFF or (ii) satisfaction of the case definition of AFF in the ASBMR Task Force's report published in JBMR Vol. 29, Issue 1, p. 14, Table 3 (2014).

"Medical Records" means the entire record maintained by an individual healthcare provider or facility (including without limitation a dentist or dental facility) relating to the medical and/or dental history, care, diagnosis and treatment of a Product User Claimant including new patient intake forms completed by or on behalf of a Product User Claimant, doctor's notes, dentist's notes, nurse's notes, physician's orders, consultation reports, laboratory test results, x-ray reports, CT scan reports, MRI scan reports, reports of any diagnostic procedures, tests or imaging studies, operative reports, history and physicals, pathology reports, admission summaries, discharge summaries, consent forms, prescription or medication administration records, and all communications between a healthcare provider and a Product User Claimant or between two or more healthcare providers relating to a Product User Claimant.

"Pharmacy Records" means all documents that relate to the preparation, dispensing and provision of medicine, medical devices, or other treatment modalities by a pharmacy or any other Person that dispenses prescription medication, or from a provincial healthcare organization that has a central registry of all prescriptions dispensed to an individual.

"PME Records" means Product Identification Documentation and Supporting Medical Documentation.

"Product Identification Documentation" means the following (in each case for the entire period of time spanning the first alleged use of Fosamax, Fosavance and/or generic Alendronate, through the alleged Eligible Event(s)):

(a) i. Pharmacy Records from all pharmacies that dispensed Fosamax, Fosavance and/or generic Alendronate to the Product User Claimant, or

ii. in the event any Product User Claimant's Pharmacy Records no longer exist because said records were destroyed pursuant to a records retention policy, natural disaster or some other reason independent of the Product User Claimant,

A. objective evidence satisfactory to the Claims Administrator, the Merck Parties and Lead Counsel that Pharmacy Records evidencing the prescription of Fosamax, Fosavance and/or generic Alendronate for the Product User Claimant no longer exist and stating the reason such Pharmacy Records do not exist; and

B. other contemporaneous Medical Records documenting the Product User Claimant's Fosamax, Fosavance and/or generic Alendronate use (in which case the extent of such usage shall continue to be determined pursuant to Exhibit 4.7(2)(C) to the Settlement Agreement);

(b) records with respect to the Product User Claimant from a provincial healthcare organization that has a central registry of all prescriptions dispensed to an individual; or

(c) insurance records reflecting the Product User Claimant's purchase of Fosamax, Fosavance and/or generic Alendronate.

"Supporting Medical Documentation" means the following:

i. Event Records; and

ii. Medical Records from all healthcare providers (including without limitation in the case of an alleged Eligible Event of ONJ, a dentist or dental facility) who provided care and treatment to the Product User Claimant during (with respect to each alleged Eligible Event) a one year period of time preceding the alleged Eligible Event and following the alleged Eligible Event for six (6) months thereafter.

1. ALL Product User Claimants shall produce the following:

    1. A sworn statement, under a penalty of perjury, by the Product User Claimants that the PME Records produced are true, complete, and correct copies of the records provided by the healthcare (including without limitation dental healthcare) provider(s), pharmacy(ies), provincial healthcare organization(s) and/or insurance companies.

2. ALL Product User Claimants shall submit, with respect to his or her alleged Eligible Event(s):

    1. all Supporting Medical Documentation; and
    2. all Product Identification Documentation.

NOTE: If you allege more than one Eligible Event, the information provided pursuant to this Section 9 must meet the requirements set forth in this Section 9 with respect to each such alleged Eligible Event.

PART B – TO BE COMPLETED ONLY IF APPLYING FOR A LOST INCOME AWARD

NOTE: YOU MUST PROVIDE THE DOCUMENTATION SPECIFIED IN THIS PART B IN ORDER TO APPLY FOR A LOST INCOME AWARD IN ADDITION TO A POINTS-BASED AWARD FOR PERSONAL INJURY. HOWEVER, APPLICATION FOR A LOST INCOME AWARD CLAIM IS OPTIONAL; PRODUCT USERS DO NOT NEED TO APPLY FOR A LOST INCOME AWARD IN ORDER TO APPLY FOR, OR RECEIVE, A POINTS-BASED AWARD.

NOTE: THE CLAIMS ADMINISTRATOR WILL NOT MAKE TENTATIVE LOST INCOME GRANTS OF LESS THAN $27,000. ACCORDINGLY, IN ORDER POSSIBLY TO BE ELIGIBLE TO RECEIVE ANY TENTATIVE LOST INCOME GRANT, YOU ARE REQUIRED TO PRODUCE "DOCUMENTATION" (AS DEFINED BELOW) OF "SPECIFIED LOST WAGES" (AS DEFINED BELOW) OF NOT LESS THAN $27,000.

☐ I hereby make application for a Lost Income Award under the Settlement Agreement.

1. Facts Concerning Alleged Lost Income:

a. Product User Claimant's gross income from wages for each of the three consecutive 12-month periods prior to date of alleged Eligible Event:

First preceding 12-month period: $ _____

Second preceding 12-month period: $ _____

Third preceding 12-month period: $ _____

b. Product User Claimant's gross income from wages for the 12-month period immediately succeeding the date of alleged Eligible Event: $ _____ .

Note: If you allege more than one Eligible Event (in respect of which you allege to have suffered Specified Lost Wages), the information provided pursuant to this Section 1 must be separately provided with respect to each such alleged Eligible Event (although in no event shall Specified Lost Wages for overlapping periods of time be counted more than once over all Eligible Events).

2. Facts Concerning Relationship of Alleged Lost Gross Income From Wages to Alleged Eligible Event.

Please describe below how the Product User Claimant's Specified Lost Wages asserted in Section 4 of this Part B below are a result of Product User Claimant's alleged Eligible Event(s).

_____

_____

_____

_____

_____

3. Facts Concerning Reimbursement, or Eligibility for Reimbursement, of Alleged Lost Gross Income From Wages Related to Alleged Eligible Event.

Please describe below any reimbursement that the Product User Claimant has received, or may be eligible to receive, in respect of all or any portion of the Product User Claimant's alleged lost gross income from wages alleged to have been suffered as a result of Product User Claimant's alleged Eligible Event(s).

4. Asserted Specified Lost Wages.

The Product User Claimant's Specified Lost Wages are $ _____. "Specified Lost Wages" means the Product User Claimant's past lost gross income from wages, to the extent that such lost gross income from wages (i) are a result of such Product User Claimant's alleged Eligible Event(s) and (ii) have neither been reimbursed nor are eligible for reimbursement.

5. Lost Income Documentation.

It is a strict requirement of the Settlement Agreement that all Product User Claimants produce true, complete, and correct copies of Documentation of Specified Lost Wages, as detailed and described below. This is necessary for the Claims Administrator to properly evaluate whether a Product User Claimant has incurred Specified Lost Wages and the amount thereof and to perform a valuation of the Lost Income Award claim of each Product User Claimant under the Tentative Lost Income Grants Criteria. Accordingly, the Claims Administrator is going to be closely reviewing the completeness and sufficiency of the Documentation of Specified Lost Wages provided to ensure that adequate Documentation thereof has been produced and that there is no evidence that any relevant records have been withheld or in any way altered by the Product User Claimant or the Product User Claimant's counsel. Intentional withholding or alteration of records will be pursued in accordance with Section 4.6 of the Settlement Agreement with respect to fraudulent claims.

"Documentation" means (i) Medical Records, billing records, tax returns, or T4 statements of remuneration paid or (ii) any other documentation or evidence requested, or otherwise found acceptable, by the Claims Administrator (with the consent of the Merck Parties and Lead Counsel).

1. ALL Product User Claimants who apply for a Lost Income Award shall produce a sworn statement, under a penalty of perjury, by the Product User Claimants that (i) the Documentation produced (x) are true, complete, and correct copies of the records provided by the healthcare provider(s), employer(s) and/or governmental authorities, and (y) accurately reflect the Product User Claimant's gross income from wages for each of the 12- month periods covered in Section 1 of this Part B, above, and (ii) the Product User Claimant's Specified Lost Wages are not less than the amount specified in Section 4 of this Part B, and (iii) the Product User Claimant's asserted Specified Lost Wages specified in Section 4 of this Part B (x) are a result of such Product User Claimant's alleged Eligible Event(s) and (y) have neither been reimbursed nor are eligible for reimbursement.

2. ALL Product User Claimants who apply for a Lost Income Award shall submit, with respect to his or her alleged Eligible Event(s), Documentation of the Product User Claimant's gross income from wages for each of the 12-month periods covered in Section 1 of this Part B, above.

PART C – TO BE COMPLETED IN ALL INSTANCES

BY SIGNING BELOW, YOU ACKNOWLEDGE AND AGREE TO THE FOLLOWING:

A. YOU DECLARE UNDER PENALTY OF PERJURY THAT

   i. YOU ARE THE PRODUCT USER OR A LEGAL REPRESENTATIVE DISCLOSED IN SECTION 3 OF PART A ABOVE,

   ii. ALL THE INFORMATION PROVIDED AND SUBMITTED IN THIS PRODUCT USER CLAIM FORM IS TRUE AND CORRECT, AND

   iii. ALL COPIES OF PME RECORDS PROVIDED (AND DOCUMENTATION OF LOST INCOME, IF CLAIMED) ARE TRUE, COMPLETE AND CORRECT COPIES OF RECORDS PROVIDED BY APPLICABLE RECORDS CUSTODIANS.

B. IF YOU HAD PREVIOUSLY OPTED OUT OF THE CLASS ACTION OF WHICH YOU HAD BEEN A MEMBER, YOU HEREBY ELECT TO PARTICIPATE IN AND TO BE BOUND BY THE TERMS AND CONDITIONS OF THE SETTLEMENT AGREEMENT, INCLUDING WITHOUT LIMITATION SECTION 5.1 OF THE SETTLEMENT AGREEMENT. THIS MEANS, WITHOUT LIMITATION, THAT, BY EXECUTION OF THIS PRODUCT USER CLAIM FORM, PURSUANT TO THE SETTLEMENT AGREEMENT, YOU ARE GRANTING EACH RELEASEE (AS DEFINED IN THE SETTLEMENT AGREEMENT) A COMPLETE AND FINAL RELEASE OF ALL RELEASED CLAIMS/LIABILITIES (AS DEFINED IN THE SETTLEMENT AGREEMENT) AS SET OUT IN SECTION 5.1 OF THE SETTLEMENT AGREEMENT.

C. YOU WILL COMPLY WITH ANY AUDIT UNDERTAKEN IN THE DISCRETION OF THE CLAIMS ADMINISTRATOR, INCLUDING SIGNING A CONSENT FOR RELEASE OF MEDICAL INFORMATION IF REQUESTED TO DO SO. REFUSAL TO COMPLY WITH, OR INTERFERENCE WITH, AN AUDIT SHALL RESULT IN DISQUALIFICATION FROM RECEIPT OF ANY PAYMENT UNDER THE SETTLEMENT AGREEMENT, INCLUDING REVOCATION OF ANY AWARD PREVIOUSLY GRANTED.

D. YOU ARE SOLELY RESPONSIBLE TO RESOLVE, SATISFY AND DISCHARGE ANY AND ALL LIENS WITH RESPECT TO ANY AWARD GRANTED TO YOU (E.G. WHERE ANY AGENCY THAT HAS PROVIDED SOCIAL ASSISTANCE TO YOU IS ENTITLED TO A PORTION OF THE AWARD). NO LIENS MAY BE ASSERTED AGAINST MERCK, THE CLAIMS ADMINISTRATOR OR FUNDS AT ANY TIME HELD IN THE SETTLEMENT ACCOUNT.

Privacy Statement

All personal information provided by or on behalf of the Claimant to the Claims Administrator will be handled in accordance with applicable privacy laws and the Claims Administrator's privacy policies available at **www.ricepoint.com**. Such information will be used for the purposes of administering the Settlement Agreement, including evaluation by the Claims Administrator, Class Counsel, Defense Counsel, the Referee appointed by the Courts and the Courts of the Claimant's eligibility status under the Settlement Agreement. Personal information provided by the Claimant will not be disclosed without further express written consent of the Claimant, except to Class Counsel, Defense Counsel, the Referee appointed by the Courts and the Courts; to appropriate persons to the extent necessary to process claims or provide benefits under the Settlement Agreement; as otherwise expressly provided in the Settlement Agreement; pursuant to court order, or as otherwise permitted or required by law; as may be reasonably necessary in order to enforce, or for the Class Counsel or Defense Counsel to exercise their respective rights (including their respective response or appeal rights) under, the Settlement Agreement; or to the immediate family members, counsel, accountants and/or financial advisors of the Claimant (each of whom the Claimant shall instruct to maintain and honour the confidentiality of such information).

The “Claims Administrator” is defined as **RicePoint Administration Inc.**

“Defense Counsel” is defined as Merck Canada Inc. (formerly named Merck Frosst Canada Ltd.), Merck Frosst Canada & Co., Merck & Co., Inc., Merck Sharp & Dohme Corp. (formerly named Merck & Co., Inc.), Blake, Cassels & Graydon LLP and Goldman Ismail Tomaselli Brennan & Baum LLP.

“Class Counsel” is defined as McKenzie Lake Lawyers LLP.

PLEASE ENSURE THAT YOU SIGN AND DATE THIS FORM (BELOW) AND THAT YOU COMPLETE, SIGN AND DATE THE CERTIFICATE OF SERVICE OF CLAIM FORM. YOUR CLAIM WILL NOT BE PROCESSED WITHOUT THE CERTIFICATE.

Date: _____ _____

Product User Claimant’s (or Legal Representative’s) Signature

_____

Printed Name of Product User Claimant (or Legal Representative)

Date: _____ _____

Signature of Product User Claimant’s Lawyer (if any)

_____

Printed Name of Product User Claimant’s Lawyer

CERTIFICATE OF SERVICE OF CLAIM FORM

I, _____, declare that:
(insert name)

I am at least 18 years of age. My address is:

_____ _____ _____ _____
Street Address City Province Postal Code

My telephone number is: ( ) _____

On _____, I caused to be served the following document(s):
Date

CLAIM FORM(S) FOR THE CLAIM(S) OF:

_____
(insert name(s) of all Claimants whose form(s) are being served with this certificate)

by enclosing the **originals** of said document(s) in (an) envelope(s) and delivering said envelope(s) to the Claims Administrator at the following address:

Fosamax/Fosavance Class Action
RicePoint Administration
PO Box 3355
London, Ontario, Canada
N6A 4K3

in the following manner:

☐ BY MAIL: I know that the envelope was sealed, addressed to the Claims Administrator, with postage thereon fully prepaid, and placed for collection and mailing on this date, with regular Canada Post mail at:

_____ _____ ; or
City Province

☐ BY ELECTRONIC SERVICE: I submitted the documents to the Claims Administrator electronically on the following website: www.fosamaxclassaction.ca; or

☐ BY SAME-DAY OR OVERNIGHT COURIER: I enclosed the envelope(s) in an overnight courier envelope addressed to the Claims Administrator and deposited same with the overnight courier company.

I declare under penalty of perjury that all of the information provided in the Claim Form and in the Certificate of Service of Claim Form is true and correct.

Executed on _____, at _____ _____

Date City Province

_____

Printed Name

_____

Signature

Reminder Checklist:

- ☐ Please sign the above Product User Claim Form and Certificate of Service of Claim Form.
- ☐ Remember to attach supporting documentation where applicable.
- ☐ Keep a copy of the claim form and all supporting documentation for your records.

- The Claims Administrator will acknowledge receipt of your Product User Claim Form by mail within 60 days. Your Product User Claim Form is not deemed fully filed until you receive an acknowledgement postcard. If you do not receive an acknowledgement postcard within 60 days, please call the Claims Administrator toll free at **1 (866) 432-5534**.
- If you move, it is your responsibility to notify the Claims Administrator of your new address.