

CLAIM FORM
Baycol Settlement

**TO BE ELIGIBLE FOR COMPENSATION YOUR COMPLETE APPLICATION TOGETHER WITH
SUPPORTING DOCUMENTATION MUST BE FAXED TO THE CLAIMS ADMINISTRATOR OR
MAILED TO THE CLAIMS ADMINISTRATOR AND POSTMARKED NO LATER THAN
OCTOBER 25, 2006**

You must complete all pages of this Form. Attach additional pages if space is insufficient.
Please type or print legibly in black ink.

Identification of Claimant

Name:	_____			
	Name of Person taking Baycol			
Address:	_____			
	Street	City	Province	Postal Code
Telephone:	_____			
	Area code / phone no. (Ext. if applicable)			
Name of Executor, Administrator, Personal Representative of person taking Baycol (if applicable)				

Address:	_____			
	Street	City	Province	Postal Code
Telephone :	_____			
	Area code / phone no. (Ext. if applicable)			

Please Inform the Claims Administrator of all Address Changes in Writing

1. Identification of person signing this Claim (check one only):
 - ? Level I: Claimant was diagnosed with rhabdomyolysis attributable to cerivastatin ("Baycol"). Claimant did not require hospitalisation.
 - ? Level II: Claimant was diagnosed with rhabdomyolysis attributable to cerivastatin ("Baycol"). Claimant required hospitalisation but did not require dialysis.
 - ? Level III: Claimant was diagnosed with rhabdomyolysis attributable to cerivastatin ("Baycol"). Claimant required temporary dialysis or other exceptional hospital treatment.
 - ? Level IV: Claimant was diagnosed with rhabdomyolysis attributable to cerivastatin ("Baycol") Claimant required hospitalisation and as a result of my rhabdomyolysis, now requires permanent dialysis on an ongoing basis or Claimant died of rhabdomyolysis.
 - ? Level V: Claimant was diagnosed with rhabdomyolysis attributable to cerivastatin ("Baycol") and suffered serious injury caused by rhabdomyolysis not contemplated in Levels I-IV.

2. The following supporting documentation must be submitted with this Claim Form and is attached:
 - (a) All medical and hospital records relating to the diagnosis and treatment of rhabdomyolysis; OR

(b) A written authorization directed to the Claims Administrator entitling the Claims Administrator to obtain medical and hospital records on your behalf, in the form provided by the Claims Administrator.

3. As a result of the diagnosis of and treatment for rhabdomyolysis, I/Claimant suffered a loss of income from employment in the amount of _____.

4. The following documentation in support of the loss of income claim must be submitted with this Claim Form and is attached:

(a) Documentation from my/Claimant's employer confirming the number of hours or days of work that I/Claimant missed and my salary on an hourly, weekly, biweekly, monthly or other basis.

6. I have not applied for or received compensation in respect of Baycol anywhere else in the world.

7. I declare under penalty of perjury that the information on this Claim Form is true, correct and complete to the best of my knowledge, information and belief.

Date: _____

Signature of Claimant

To preserve eligibility for benefits under the settlement, your completed application, together with the required documentation must be submitted to the Claims Administrator no later than OCTOBER 25, 2006.

THE INFORMATION PROVIDED IN THIS FORM WILL REMAIN CONFIDENTIAL

Please mail or fax this Form to the following address:

**CLAIMS ADMINISTRATOR
Crawford Class Action Services
Suite 101, 515 Riverbend Drive
Kitchener, Ontario, N2K 3S3**

Fax Number: 1-888-842-1332