

EXHIBIT “F”
Cardozo Class Action Settlement
Claim Form Package Overview

This Claim Form Package contains a:

- Privacy Statement
- Instructions for Settling Claimants
- Claim Form
- Health Practitioner Form
- Opt Out Form

PRIVACY STATEMENT

Personal Claimant Information 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 Cardozo Settlement Agreement,
- To evaluate and consider the claimant's eligibility status under the Cardozo Settlement Agreement,
- Is strictly private and confidential and will not be disclosed without the express written consent of the claimant, except as provided in the Cardozo Settlement Agreement.

INSTRUCTIONS FOR SETTLING CLAIMANTS:

To establish your right to compensation under the terms and conditions of the Cardozo Settlement Agreement, you must submit a completed Claim Form, completed Health Practitioners Form and provide the necessary supporting documentation to the Claims Administrator, postmarked no later than the claim deadline. Please detach your completed Claim Form and completed Health Practitioners Form along the perforated margin and return it with your supporting documentation to the Claims Administrator at the address listed below.

IMPORTANT DEADLINES

March 8, 2006	Deadline to Opt Out of the Settlement Agreement
July 6, 2006	End of Claim Period – Deadline to File a Claim

ALL REQUIRED CLAIM FORMS AND SUPPORTING DOCUMENTATION MUST BE SUBMITTED BY THE ABOVE LISTED DEADLINES TO:

Claims Administrator, Suite 280 - 2985 Virtual Way, Vancouver, B.C. V5M 4X7 **1-866-510-8069**

In no event will claims postmarked after the Claim Deadline be considered. If you require assistance or advice regarding completion of the Claim Form or have any enquiry related to your claim, you may retain legal counsel at your own expense, or contact the Claims Administrator at cardozo@crawco.ca or **1-866-510-8069**

Please keep copies of all documentation you send to the Claims Administrator. The documentation process takes time. **ACT NOW.** Do not wait until the Claim Deadline.

EXHIBIT "C"
CARDOZO CLAIM AND OPT IN FORM
Strictly Private and Confidential

THIS FORM CONTAINS IMPORTANT INFORMATION REGARDING YOUR LEGAL RIGHTS

PLEASE READ THE ENTIRE FORM BEFORE BEGINNING TO COMPLETE THE FORM

IN THE EVENT OF CONFLICT BETWEEN THE TERMS OF THE CARDOZO SETTLEMENT AGREEMENT AND THIS FORM, THE SETTLEMENT AGREEMENT PREVAILS. A COMPLETE COPY OF THE CARDOZO SETTLEMENT AGREEMENT IS AVAILABLE AT:

www.cardozo.settlement.ca

Section 1 - Claimant Identification – must be completed in all cases

Claimant Last Name _____

First Name _____ Middle Name _____

Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Date of Birth: Year _____ Month _____ Day _____

Date of Death (if Applicable): Year _____ Month _____ Day _____ Death Certificate Included

Home Phone (____) - ____ - _____ Work Phone (____) - ____ - _____ Fax (____) - ____ - _____

EVERY MEMBER OF THE SETTLEMENT CLASS THAT IS A RESIDENT OF BRITISH COLUMBIA IS BOUND BY THE CARDOZO SETTLEMENT AND BY THE ORDER OF THE BRITISH COLUMBIA SUPREME COURT APPROVING THE SETTLEMENT UNLESS HE OR SHE "OPTS OUT" OF THE SETTLEMENT IN ACCORDANCE WITH THE TERMS OF THE ORDER AND THE SETTLEMENT AGREEMENT. A NON-RESIDENT MEMBER OF THE SETTLEMENT CLASS IS ALSO BOUND BY THE SETTLEMENT AND THE ORDER IF HE OR SHE "OPTS IN" TO THE SETTLEMENT. THE SUBMISSION OF THIS CLAIM FORM TO THE CLAIMS ADMINISTRATOR BY OR ON BEHALF OF A NON-RESIDENT MEMBER WILL CONSTITUTE AN "OPT IN" BY THE NON-RESIDENT MEMBER, AND THE NON-RESIDENT MEMBER WILL BE BOUND BY THE SETTLEMENT AND THE ORDER AS IF HE OR SHE WERE A RESIDENT MEMBER OF THE SETTLEMENT CLASS.

Mail or Deliver this Form, together with all Supporting Documentation, no later than the Claim Deadline (July 6, 2006) to:

**Cardozo Class Action Settlement Administrator
Suite 280 - 2985 Virtual Way
Vancouver, B.C.
V5M 4X7**

Section 2 - Representative Identification

Complete this section only if you are a litigation guardian on behalf of a person under disability, litigation administrator on behalf of an estate, personal representative or heir.

You MUST complete Section 1 and identify the primary Claimant who is your source of entitlement to make a claim. You MUST also provide proof of your authority to act as representative of a claimant.

I am applying on behalf of a Claimant who is

A minor (under 18 years of age)

Please enclose a copy of your authority to act on behalf of a minor. e.g. copy of birth or baptismal certificate.

A person under legal disability

Please enclose a copy of your authority to act on behalf of a person under legal disability

An estate

Please enclose a copy of your authority to act on behalf of an Estate. e.g. copy of will

Relationship to Primary Claimant

Custodial Parent

Litigation Administrator

Personal Representative

Representatives Last Name _____

First Name _____ Middle Name _____

Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Home Phone (____) - ____ - _____ Work Phone (____) - ____ - _____ Fax (____) - ____ - _____

Section 3 – Legal Representative Identification

This section is to be completed only if a lawyer is representing the applicant. All correspondence will be sent to your lawyer who must notify the claims administrator of any change in mailing address. If you change your legal representative, you must notify the Claims Administrator in writing of the new information.

Name of Law Firm _____

Lawyer's Last Name _____ First Name _____

Address _____ P.O. Box _____

City _____ Province _____ Postal Code _____

Home Phone (____) - ____ - _____ Work Phone (____) - ____ - _____ Fax (____) - ____ - _____

Section 4 – Category 1 - Re-Testing (Kimberley) Subclass (“Subclass RT”)

Complete this section only if you were tested for Gonorrhoea or Chlamydia at the Kimberley Regional and District Hospital B.C. between October 1, 2000 and May 24, 2002.

GO TO SECTION 5 if you were tested at the East Kootenay Regional Health Center B.C. between May 25, 2002 and July 30, 2003.

(Check (√) the appropriate box)

1. I was tested for: Gonorrhoea or,
 Chlamydia

at the Kimberley Regional and District Hospital B.C. between October 1, 2000 and May 24, 2002.

Yes No (Check (√) only one box)

2. The Kimberley Regional and District Hospital B.C. notified me that my test result was incorrect or unreliable.

Yes No (Check (√) only one box)

3. I was re-tested upon learning of my incorrect or unreliable initial test result.

Yes No (Check (√) only one box)

4. I received a letter confirming my re-test result.

Yes No (Check (√) only one box)

If you answered “No” to Question 4.1 you are not eligible to participate in this class action settlement and need to do nothing further

Section 5 – Re-Testing (East Kootenay) Subclass (“Subclass RT”)

Complete this section only if you were tested for Gonorrhoea or Chlamydia at the East Kootenay Regional Health Center B.C. between May 25, 2002 and July 30, 2003.

GO TO SECTION 4 if you were tested at the Kimberley Regional and District Hospital B.C. between October 1, 2000 and May 24, 2002.

(Check (√) the appropriate box)

1. I was tested for: Gonorrhoea or,
 Chlamydia

at the East Kootenay Regional Health Center B.C. between May 25, 2002 and July 30, 2003.

Yes No (Check (√) only one box)

2. The East Kootenay Regional Health Center B.C. notified me that my test result was incorrect or unreliable.

Yes No (Check (√) only one box)

3. I was re-tested upon learning of my incorrect or unreliable initial test result.

Yes No (Check (√) only one box)

4. I received a letter confirming my re-test result.

Yes No (Check (√) only one box)

If you answered “No” to Questions 5.1 you are not eligible to participate in this class action settlement and need to do nothing further

Section 6 – Levels of Compensation

Select Category below that best describes your claim – NOTE THAT YOU CANNOT CHOOSE MORE THAN ONE CATEGORY.

Category 1 Re-Testing Subclass (“Subclass RT”) – Compensation of \$400.00

If you were tested for Gonorrhoea or Chlamydia at the Kimberley Regional and District Hospital B.C. between October 1, 2000 and May 24, 2002 or, at the East Kootenay Regional Health Center B.C. between May 25, 2002 and July 30, 2003, and subsequently received an “incorrect or unreliable” test result and were later re-tested, you must fully complete and submit this claim form to the Claims Administrator, (included with this Claim Form Package) before the Claims Deadline.

Category 2 False Negative Subclass (“Subclass FN”) – Compensation of \$900.00

You must provide the proof necessary for Category 1, together with a fully completed and signed Health Practitioner Claim Form (included). You must also complete the declaration below and provide any additional proof required by the Administrator to support your Category 2 claim.

(check (√) only those boxes that are true)

I do solemnly declare that:

- My initial test result was negative,
- My initial diagnosis was negative,
- I was diagnosed positive at some point after my initial diagnosis and I was not infected between the initial negative test result and the subsequent positive diagnosis

Category 3 False Positive Subclass (“Subclass FP”) – Compensation of \$500.00

You must complete the declaration below and must submit to the Administrator together with a fully completed and signed Health Practitioner Claim Form (included). You must also provide any additional proof required by the Administrator to support your Category 3 claim.

(check (√) only those boxes that are true)

I do solemnly declare that:

- I was notified by the British Columbia Interior Health Authority that I received a false positive test result.
- My initial diagnosis was positive as a result of the false positive test result,
- I was treated for Chlamydia or Gonorrhoea as a result of the false positive diagnosis.

Section 7 - Declaration

I solemnly swear that all of the information provided by me on this Claim Form is true, correct and complete, and I make this declaration conscientiously believing it to be true and with the understanding that the presiding Court has ordered Settlement Class Members not to submit a Claim Form knowing that it contains false or incorrect information, I may be subject prosecution for fraud under sections 380(1) and 381 of the Criminal Code of Canada. I also understand and agree that if requested by the Claims Administrator , pursuant to the terms of the Settlement Agreement, I will meet with the Claims Administrator for a brief interview, following submission of the documentation required to prove my Claim.

Claimant Signature

(DD/MM/YYYY)

IF YOU ARE CLAIMING CATEGORY 2 OR CATEGORY 3 COMPENSATION, THIS DOCUMENT MUST BE SIGNED IN THE PRESENCE OF A COMMISSIONER OF OATHS OR NOTARY PUBLIC AND THE COMMISSIONER OR NOTARY PUBLIC’S SEAL AND SIGNATURE MUST BE ATTACHED.

Commissioner/Notary Signature

(DD/MM/YYYY)



EXHIBIT "B" – OPT OUT FORM

NO. S83059
New Westminster registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

**DANIELLE CARDOZO, an infant,
by her Litigation Guardian, DARLENE CARDOZO**

Plaintiff

-and-

BECTON, DICKINSON AND COMPANY

Defendant

Brought under the Class Proceedings Act, R.S.B.C. 1996, c.50

OPT OUT FORM

For British Columbia Residents Only

THIS IS NOT A CLAIM FORM. Completing and returning this Opt Out Form will exclude you from receiving any compensation available under the Cardozo Class Action Settlement.

I, [NAME] _____

of [ADDRESS] _____

DO NOT WISH TO PARTICIPATE in this Class Action or in the Cardozo Class Action Settlement.

I understand that this action is brought on behalf of all persons who claim to have suffered damages as a consequence of being tested for Gonorrhoea or Chlamydia using a BD Probetec ET machine that was defective. The action has been certified as a class proceeding (the "Class Action"). I also understand that the court has approved a settlement of the Class Action (the "Settlement").

I understand that if I opt out and complete this form, I will not take part in the Class Action or the Settlement. I agree to be excluded from both the Class Action and the Settlement.

I also understand that a lawsuit must be commenced within a specified limitation period or it will be legally barred. The certification of this Class Action suspended the running of the limitation period from the time the Class Action was filed. The limitation period will resume running against me if I opt out of the Class Action. By opting out of the Class Action, I take full responsibility for obtaining legal advice about the limitation period and for taking all legal steps necessary to protect my claim.

Date

Signature of Witness

Signature

Print Name of Witness

Print Name

Address of Witness

Address

MAIL OR DELIVER NOT LATER THAN MARCH 8, 2006 (OPT OUT DEADLINE) TO:

**Cardozo Class Action Settlement Administrator
Suite 280 - 2985 Virtual Way
Vancouver, B.C.
V5M 4X7**

IF YOU SEND THIS FORM BY MAIL, IT MUST BE CLEARLY POSTMARKED NO LATER THAN THE OPT OUT DEADLINE,

No person may opt out minors or mentally incapable persons without permission of the Court after notice to the Children's Lawyer and/or the Public Guardian or Trustee.

EXHIBIT “E”
Cardozo Class Action Settlement
Health Practitioner’s Form

To Be Completed By the Patient’s Treating Health Practitioner

PRIVACY STATEMENT

Personal Patient Information is collected, used, and retained by the Cardozo Class Action Settlement Administrator pursuant to the Personal Information Protection and Electronics Documents Act. S.C. 2000, c.5 (PIPEDA):

- For the purpose of administering the Cardozo Class Action Settlement Agreement,
- To evaluate and consider the patient’s eligibility status under the Cardozo Class Action Settlement Agreement,
- Is strictly private and confidential and will not be disclosed without the express written consent of the patient, except as provided in the Cardozo Class Action Settlement Agreement.

A. Patient Information

Patient Name	Patient DOB	Patient Address	City, Province, PC
Date of Initial Test	Tested For <input type="checkbox"/> Gonorrhoea or, <input type="checkbox"/> Chlamydia	Where Tested <input type="checkbox"/> Kimberley Regional and District Hospital B.C <input type="checkbox"/> East Kootenay Regional Health Center B.C.	Result(s) <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate
Date of Re-Test			Result(s) <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate

B. Health Practitioner Information – Please provide your name, office address, telephone number, e-mail address, if any.

 (First Name) (Middle Initial) (Last Name)

 (Office Address)

 (City) (Prov/Terr) (Postal Code)

 (Area Code and Telephone Number)

C. Health Practitioner Declaration

I declare that to the best of my knowledge, the Patient was tested for Gonorrhoea or, Chlamydia and received a false positive or false negative result and was subsequently re-tested on the date indicated above. The relevant supporting medical records are attached to this form.

(Date: DD/MM/YYYY)

(Signature of Treating Health Practitioner)

This form is an official Court document sanctioned by the Court and submitting it to the Cardozo Class Action Settlement Administrator is equivalent to filing it with a Court.

Please Return To:

**Cardozo Class Action Settlement Administrator
Suite 280 - 2985 Virtual Way
Vancouver, B.C.
V5M 4X7**

