Federal Indian Hospitals Class Action Settlement

CLAIM FORM

About the Settlement

From 1936 to 1981, the Government of Canada operated hospitals called Federal Indian Hospitals. Under the Settlement of the class action lawsuit, *Ann Cecile Hardy v. The Attorney General of Canada* (Federal Court File No. T-143-18), individuals who were admitted to these hospitals may be eligible for compensation for psychological, verbal, physical, and/or sexual abuse they experienced while admitted. The Settlement Agreement excludes compensation for any claim connected to medical treatment at Federal Indian Hospitals. The Settlement was approved by the Federal Court on June 24, 2025.

If you were admitted to any of the **33 Federal Indian Hospitals** during the dates of operation listed in the Settlement Agreement, you may be eligible for compensation if you suffered an eligible abuse/harm while admitted. An Eligible Claimant may receive compensation ranging from $10,000 to $200,000, based on the severity of abuse/harm they experienced. If a Claimant passed away on or after January 25, 2016, the Estate or Heir may be eligible to receive compensation.

The documents for this class action use some words now recognized as inaccurate, insensitive, and offensive. These words come from a period of Crown-Indigenous relations not grounded in reconciliation. These words are only used when necessary for legal accuracy, or when referring to historical sources.

For more information about this Settlement, please visit www.ihsettlement.ca.

How to access support concerning this Settlement

Emotional and mental health support

Filling out this Claim Form may be emotionally difficult or traumatic for some individuals. If you or someone you are assisting are experiencing emotional distress and want to talk to someone, culturally competent counsellors are available 24 hours a day through the Hope for Wellness Helpline to provide free support and crisis intervention services. **Call 1-855-242-3310 or visit www.hopeforwellness.ca.**

Help with the claims process

You can get help completing the Claim Form, or further information about the claims process. **Call 1-888-592-9101 for assistance.**

Class Counsel and available legal advice

If you need legal support or help locating a lawyer to help you complete the Claim Form, **please visit www.ihsettlement.ca/contact.**

- **Important reminder:** A limited amount of legal advice or support with your Claim may be paid by the Government of Canada, in accordance with the terms of the Settlement Agreement and **Individual Legal Fees Protocol**.

Who may be eligible for compensation

To be eligible for compensation:

To be eligible for compensation, you must fill out, sign, and submit a completed Claim Form, along with any supporting documents, to the Claims Administrator (by email, fax or mail by the Claims Deadline of July 27, 2028). The completed Claim Form must show:

- Claimant was admitted to one of **33 Federal Indian Hospitals** included on the list in the Settlement Agreement during any period(s) when the hospital was operated by the Government of Canada within the Class Period; and
- Claimant experienced psychological, verbal, physical, and/or sexual abuse (not connected to medical treatment) while admitted at the Federal Indian Hospital.

Who can submit a Claim Form

Claim Forms can be submitted by:

- An Individual Claimant, OR
- A Representative of the Claimant:
  - The Estate Representative or the Heir of a Claimant who has passed away; OR
  - The Personal Representative of a Claimant who is a Person Under Disability; OR
  - Individual Legal Counsel (a practising lawyer in good standing in a Canadian province/territory) who has been hired by the Claimant or Representative.

Ways to submit a Claim Form

Refer to **Appendix F: Completed Claim Form Checklist** for all requirements and documentation.

Online (recommended) – Complete your entire Claim process through the online portal.

Online Portal:
https://portal.ihsettlement.ca

Digital PDF – Save this Claim Form to your computer as a PDF, complete using Adobe Acrobat and submit.

By email:
claims@admin.ihsettlement.ca

Physical Copy – Print this Form, complete the required information by writing clearly in ink and submit. Copies of information and documentation submitted will not be returned nor copies made available.

By mail:
FIH Claims Administrator
P.O. Box 5493 STN MAIN
Newmarket, ON L3Y 0J4

By fax:
416-966-5701

The deadline to submit a Completed Claim Form to the Claims Administrator is JULY 27, 2028

Index of Claim Form

<u>Important:</u> Please ensure that you take the time to read the Claim Form carefully and complete all required sections <u>before</u> you submit your Claim.

PART 1 | Privacy Release, Acknowledgement, and Retention Policy (Required)

The Claims Administrator will be collecting your personal information throughout this Claim Form to process your Claim. The Claims Administrator is not subject to the Privacy Act, R.S.C. 1985, c. P-21, but remains subject to applicable privacy legislation, including PIPEDA and provincial equivalents. Please refer to the **Data Disposition Protocol** for further information. By signing this Privacy Release and Acknowledgement you recognize that your personal information will be used to process your Claim as required in accordance with the Settlement Agreement and its related Protocols.

Privacy Release and Acknowledgement

I acknowledge and recognize that the Claims Administrator and Independent Reviewer:

1. do not represent the Federal Indian Hospitals or the Government of Canada;
2. do not act as an agent or legal counsel for any party, and do not offer legal advice; and,
3. do not have any duty to identify or protect the legal rights of any party, or to raise an issue not raised by any party.

Privacy: I acknowledge and understand that it will be necessary for the purposes of processing my Claim:

- for the Claims Administrator to share information provided in this Claim for verification or review to the Government of Canada, the Independent Reviewer, the Exceptions Committee (if applicable), and Class Counsel; and
- for the Government of Canada to share information in its possession to the Claims Administrator, the Independent Reviewer, the Exceptions Committee (if applicable), and Class Counsel.

I confirm that all the information provided in this Claim Form is true to the best of my knowledge. Where someone helped me complete this Claim Form, that person has read to me everything they wrote and included with this Claim Form (including any attachments or supporting documentation).

I understand that I may hire any lawyer of my choosing to provide legal advice and/or assist me in completing and/or submitting my Claim Form.*

Consent: I understand that by submitting this Claim Form to the Claims Administrator along with with any supporting documents, I am consenting and agreeing to the information on this page, and to the sharing of my personal information to process this Claim as required and in accordance with the Settlement Agreement and related Protocols.

* Important: The Government of Canada, in accordance with the Settlement Agreement and Individual Legal Fees Protocol, will pay a practising lawyer in good standing in a Canadian province or territory an amount up to 5% (plus applicable taxes) of the value of the compensation award for this assistance. This payment will not be deducted from the Claimant's compensation payment. Any amount above the 5% (up to a total of 10%) must be approved by the Court.

Retention Policy

As required under the Settlement Agreement and related Protocols, your personal information will be kept for two (2) years after the Claims Administrator completes the last payment of compensation under the Settlement Agreement. After this, the Claims Administrator will destroy all Claimant information and documentation in its possession.

SIGN

I acknowledge and agree to all of the terms outlined above.

First name (printed)

Last name (printed)

Signature (required)

Day (DD) / Month (MM) / Year (YYYY)

PART 1A | Claimant Details (Required)

Please ensure that you provide all required information and answer all required questions in order for your Claim Form to be considered complete. Claims can only be processed if all required Claimant details and documentation are submitted. Incomplete Claim Forms may not be processed, and the Claims Administrator may contact you if additional details are needed.

Important:

- This section is intended to collect information about the Claimant. If you are completing this form on behalf of someone else, the terms "you" and "your" refer to the Claimant.
- If you change your legal name at any time during the claims process, please notify the Claims Administrator immediately and provide supporting documentation of the name change. This will help ensure your claim is processed without delay.

Your name (required)

Your name must match your government-issued identification (ID).

First name:

Middle name (if applicable):

Last name:

Identification (required)

☐ **Please attach** a copy of your Federal or Provincial government-issued ID to your application.

Examples of accepted ID:

- Certificate of Indian Status (Status Card)
- Inuit Beneficiary Card
- Métis Citizenship Card
- Passport
- Driver's License
- Provincial/Territorial Photocards
- Health Card

Other name(s): Did you use any other names while you were admitted to a Federal Indian Hospital? For example, a maiden name, birth name, nickname, adopted name, or an E-Disc/W-Disc name or number (for Inuit Claimants).

☐ Yes →

If yes, please provide the other name(s):

Documentation (if available)

☐ **Please attach** a copy of any documents that could provide confirmation of your other names.

Examples of documents that could confirm other names:

- Legal name change order
- Marriage certificate / divorce papers
- Adoption papers
- Other documents that reference your other names

Your Social Insurance Number (SIN) (optional)

			-				-			

Send only copies of documents (photocopy, scan, fax or photo) – do not send original documents.

Please write the Claimant's first and last name and date of birth (as entered in **Part 1A** of this Claim Form) clearly on every page of each copy you include. This will ensure that all documentation is matched to the correct Claim Form. Please make sure all copies are clear and easy to read.

PART 1A | Claimant Details (Required)

Your date of birth (required)
Date of birth must match your government-issued ID.

Day (DD) / Month (MM) / Year (YYYY)

Claimant date of death (if applicable)
If the Claimant has passed away, please provide the date of death on or after January 25, 2016.

Day (DD) / Month (MM) / Year (YYYY)

Important: Stop here if the Claimant is deceased and passed away before January 25, 2016.
Claimants who died before January 25, 2016 are not eligible for this Settlement.

Providing First Nation, Métis or Inuit status information may be helpful and is optional.

Are you a member of a First Nation, Métis or Inuit community? (if applicable)
If "yes", select the one that applies by placing an "X" in the box and complete all the associated questions.

☐ **First Nation**

- Your Status Card or registration number:
- Name of your First Nation or Band:
- Province or Territory where your First Nation or Band is located:
- If you cannot provide your Status Card or registration number or Band name, please explain why:

OR

☐ **Métis**

- Your Métis citizenship or membership number:
- Your issuing Métis organization:
- Province or Territory where your Métis organization or community is located:
- If you cannot provide your Métis citizenship or membership number or issuing organization, please explain why:

OR

☐ **Inuit**

- Disc number:
- Beneficiary number:
- Province or Territory where your Inuit region or community is located:
- If you cannot provide your disc or beneficiary number, please explain why:

PART 1B | Claimant Contact Information (Required)

Claimant contact information must be completed below. Please ensure that you provide all required information and answer all required questions in order for your Claim Form to be considered complete.

Important:

- This section is intended to collect information about the Claimant. If you are completing this form on behalf of someone else, the terms "you" and "your" refer to the Claimant.
- If the Claimant is deceased, you do not need to fill out the mailing address, email and phone number below.
- If you need to change your contact information (for example: your mailing address, email, or phone number), please contact the Claims Administrator at **1-888-592-9101**.

In addition, if you are:

- applying on behalf of a deceased Claimant, please complete **Appendix C**.
- applying on behalf of a Claimant who is a Person Under Disability, please complete **Appendix D**.
- Individual Legal Counsel for the Claimant or the person applying on their behalf, please complete **Appendix E**.

Your mailing address (required)

- **Note:** If you are deemed to be eligible for compensation under the Settlement and you choose to have your compensation sent to you as a cheque, the cheque will be mailed to this address. If you move, please provide your new contact information to the Claims Administrator at **1-888-592-9101**.

Street number | Street name

Unit | P.O. Box (if applicable)

City / Town / Community | Postal Code

Province / Territory | Country

C/O Name (if applicable)

If your mailing address is a facility (such as a correctional or medical facility) or a public place (such as a hotel or Friendship Centre), or if you are staying with a friend or family member, please include the name.

Your email address (if available):

Your telephone number (recommended): - - Ext.

Please select the phone number you provided: ☐ Home ☐ Mobile ☐ Work ☐ Other:

PART 2 | Hospital Admission – Name and Dates (Required)

To be eligible for compensation, you must have been admitted to one of the **33 Federal Indian Hospitals** listed below while it was operated by the Government of Canada (refer to eligible dates of operation) when you suffered an abuse/harm. Please ensure that you provide all required information and answer all required questions in order for your Claim Form to be considered complete.

- **Important:** You will have an opportunity to provide additional information about your admission to a Federal Indian Hospital in **Part 2A**. For now, please only enter the requested information.

Select only the hospital(s) where you were admitted when you experienced the abuse/harm you are claiming for.

- If you were admitted to more than one hospital where you experienced abuse/harm, select all applicable ones.
- For each hospital that you were admitted to when an abuse/harm occurred, provide the first and last month/year of your admission(s), referring to the eligible dates of operation provided below. You should do this to the best of your recollection.
- If you were admitted to more than one hospital and experienced abuse/harm on each occasion, you should fill out and attach **Appendix A** for each additional admission.

Alberta

Select the hospital(s) where you were admitted	Eligible dates of operation	Month (MM) / year (YYYY) your admission ***BEGAN***	Month (MM) / year (YYYY) your admission ***ENDED***
☐ **Blackfoot Indian Hospital** Other name(s): Blackfoot I.N.H.S. Hospital, Blackfoot Hospital	January 1, 1936 - April 1, 1976	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Blood Indian Hospital** Other name(s): Blood Agency Hospital, Blood Hospital, Blood Reserve Indian Hospital, Blood Reserve Hospital, Moses Lake Hospital	January 1, 1936 - December 31, 1981	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Charles Camsell Indian Hospital** Other name(s): Charles Camsell Hospital, Edmonton Indian Hospital, Edmonton Military Hospital, Indian Health Services Hospital, Jesuit College Hospital	November 1, 1945 - December 1, 1980	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Hobbema Indian Hospital** Other name(s): Hobbema Hospital	January 1, 1952 - June 30, 1963	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Morley Stoney Indian Hospital** Other name(s): Morley Indian Hospital, Morley Hospital, Stoney Agency Hospital, Stoney Indian Hospital, Stoney Hospital, Stony Indian Hospital, Stony Hospital	January 1, 1936 - December 31, 1960	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Peigan Indian Hospital** Other name(s): Peigan Agency Hospital, Peigan Hospital	January 1, 1936 - December 31, 1954	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Sarcee Indian Hospital** Other name(s): Sarcee Agency Hospital, Sarcee Hospital, Sarcee Reserve Indian Hospital	January 1, 1936 - March 31, 1946	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐

British Columbia

Select the hospital(s) where you were admitted	Eligible dates of operation	Month (MM) / year (YYYY) your admission ***BEGAN***	Month (MM) / year (YYYY) your admission ***ENDED***
☐ **Coqualeetza Indian Hospital** Other name(s): Coqualeetza Hospital	September 1, 1941 - September 30, 1969	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Miller Bay Indian Hospital** Other name(s): Millar Bay Hospital, Miller Bay Hospital	September 16, 1946 - October, 1, 1971	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Nanaimo Indian Hospital** Other name(s): Nanaimo Hospital	September 1, 1946 - November 20, 1966	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐

PART 2 | Hospital Admission – Name and Dates (Required)

Manitoba

Select the hospital(s) where you were admitted	Eligible dates of operation	Month (MM) / year (YYYY) your admission ***BEGAN***	Month (MM) / year (YYYY) your admission ***ENDED***
☐ **Brandon Indian Hospital** Other name(s): Assiniboine Hospital, Brandon Sanatorium	June 15, 1947 - January 31, 1961	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Clearwater Lake Indian Hospital** Other name(s): Clearwater Hospital, Clearwater Lake Hospital, Clearwater Lake Sanatorium, Orok Indian Hospital, The Pas Hospital	September 24, 1945 - February 28, 1965	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Dynevor Indian Hospital** Other name(s): Dynevor Indian Sanatorium, Dynevor Hospital, Dynevor Sanatorium	September 1, 1939 - November 1, 1957	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Fisher River Indian Hospital** Other name(s): Fisher River Hospital	July 6, 1940 - June 18, 1973	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Fort Alexander Indian Hospital** Other name(s): Fort Alexander Hospital, Pine Falls Indian Hospital, Pine Falls Hospital	December 1, 1937 - November 18, 1964	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Norway House Indian Hospital** Other name(s): Norway House Agency Hospital, Norway House Hospital	January 1, 1936 - December 31, 1981	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Percy E. Moore Hospital**	June 18, 1973 - December 31, 1981	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐

New Brunswick

Select the hospital(s) where you were admitted	Eligible dates of operation	Month (MM) / year (YYYY) your admission ***BEGAN***	Month (MM) / year (YYYY) your admission ***ENDED***
☐ **Tobique Indian Hospital** Other name(s): Tobique Hospital	January 1, 1936 - March 31, 1950	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐

Northwest Territories and Nunavut

Select the hospital(s) where you were admitted	Eligible dates of operation	Month (MM) / year (YYYY) your admission ***BEGAN***	Month (MM) / year (YYYY) your admission ***ENDED***
☐ **Edzo Cottage** Other name(s): Edzo Cottage Hospital, Rae-Edzo Cottage Hospital, Rae-Edzo Hospital	August 7, 1974 - December 31, 1981	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Fort Norman Indian Hospital** Other name(s): Bishop Bompas Memorial, Fort Norman Hospital, Indian Hospital at Fort Norman	September 1, 1943 - January 21, 1946	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Fort Simpson Indian Hospital** Other name(s): Fort Simpson Cottage Hospital, Fort Simpson General Hospital	September 20, 1973 - December 31, 1981	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Frobisher Bay Indian Hospital** Other name(s): Frobisher Bay General Hospital, Frobisher Bay Hospital	April 1, 1959 - December 31, 1981	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐
☐ **Inuvik Indian Hospital** Other name(s): Inuvik General Hospital, Inuvik Hospital, l'Hôpital Général d'Inuvik	January 13, 1961 - December 31, 1981	☐☐ / ☐☐☐☐	☐☐ / ☐☐☐☐

PART 2 | Hospital Admission – Name and Dates (Required)

Ontario

Select the hospital(s) where you were admitted	Eligible dates of operation	Month (MM) / year (YYYY) your admission ***BEGAN***	Month (MM) / year (YYYY) your admission ***ENDED***
☐ **Lady Willington Indian Hospital** Other name(s): Lady Willingdon Hospital	January 1, 1936 - September 30, 1968	/	/
☐ **Manitowaning Indian Hospital** Other name(s): Manitoulin Isolation Hospital, Manitoulin Isolation Unit, Manitowaning Hospital	January 1, 1941 - March 31, 1951 January 1, 1959 - March 31, 1962	/	/
☐ **Moose Factory Indian Hospital** Other name(s): Moose Factory General Hospital, Moose Factory Hospital, Moose Factory Zone Hospital	September 9, 1950 - December 31, 1981	/	/
☐ **Sioux Lookout Indian Hospital** Other name(s): Indian Hospital Sioux Lookout, Sioux Lookout Hospital, Sioux Lookout Zone Hospital	December 12, 1949 - December 31, 1981	/	/
☐ **Squaw Bay Indian Hospital** Other name(s): Squaw Bay Hospital, Squaw Bay Sanatorium	May 1, 1942 - May 31, 1953	/	/

Saskatchewan

Select the hospital(s) where you were admitted	Eligible dates of operation	Month (MM) / year (YYYY) your admission ***BEGAN***	Month (MM) / year (YYYY) your admission ***ENDED***
☐ **Fort Qu'Appelle Indian Hospital** Other name(s): F.Q.I.H., Fort Qu'Appelle Hospital, Qu'Appelle Indian Hospital	May 1, 1936 - December 31, 1981	/	/
☐ **North Battleford Indian Hospital** Other name(s): North Battleford Hospital	May 15, 1949 - August 26, 1977	/	/

Yukon

Select the hospital(s) where you were admitted	Eligible dates of operation	Month (MM) / year (YYYY) your admission ***BEGAN***	Month (MM) / year (YYYY) your admission ***ENDED***
☐ **Mayo Hospital** Other name(s): Mayo General Hospital	April 1, 1970 - December 31, 1981	/	/
☐ **Watson Lake** Other name(s): Watson Lake Cottage Hospital, Watson Lake Hospital	March 1, 1966 - December 31, 1981	/	/
☐ **Whitehorse Indian Hospital** Other name(s): Regional Hospital at Whitehorse, Whitehorse General Hospital, Whitehorse Hospital	April 1, 1959 - December 31, 1981	/	/

PART 2A | Hospital Admission – Additional Information (Required)

In this section, you need to provide hospital admission details to help the Claims Administrator assess and process your Claim.

- **Important:** In **Part 2B**, you will share the details of the abuse/harm that you experienced while admitted at a Federal Indian Hospital.

Please provide as much information as you can remember about your admission to the Federal Indian Hospital(s) listed in **Part 2**. Your answers to the questions below will help us understand your admission and assess your eligibility as a Claimant and for compensation. Please ensure that you provide all required information and answer all required questions in order for your Claim Form to be considered complete.

- **Important:** If you were admitted to more than one hospital and experienced abuse/harm on each occasion, you should fill out and attach **Appendix A** for each additional admission.

Information about your admission (required)

For each Federal Indian Hospital admission, answer the following questions as best as you can. Please provide as much information as you are comfortable sharing. *Example answers are provided as guidance only to assist you.*

- **Important:** For each additional hospital admission, where an abuse/harm occurred (if applicable), please complete **Appendix A** and provide answers to required questions.

1. **What is the name of the hospital you were admitted to?** *Example: Charles Camsell Hospital.*

2. **For how long were you admitted to the hospital?** *Example: 3 months.*

3. **What was the reason for your admission?** *Example: Tuberculosis treatment.*

4. **Where did you live before being admitted to the hospital (including address if known)?** *Example: St. Mary's Indian Residential School.*

5. **Why did you go to this particular hospital (instead of another)?** *Example: It was the closest hospital to my community.*

6. **How did you get to and from the hospital at the beginning and end of your admittance?** *Example: By ship.*

7. **What are the names of any of the doctors, nurses, or other staff who assisted you?** *Example: Dr. Smith, Nurse Johnson.*

8. **What types of medical treatment did you receive?** *Example: Antibiotics, physical therapy.*

PART 2A | Hospital Admission – Additional Information (Required)

9. Were you transferred to/from another hospital or medical facility before/after being admitted to the Federal Indian Hospital? *Example: Transferred to a Tuberculosis (TB) Sanitorium after admission.*

Additional details (recommended)

This section is for you to share any other details you can remember about your admission at the Federal Indian Hospital. For example, other patients' names or a description of the hospital. Please fill in what you feel comfortable sharing. Do not include information about any eligible abuse/harm you may have experienced here. You will be asked about this later in **Part 2B** of the Claim Form.

Relevant documents (if available)

Please provide any relevant documents you may have related to your admission to a Federal Indian Hospital. Providing documents is optional but may be helpful in the assessment of your Claim. The following checklist is meant to help you think about documents or information that you may have that could support your Claim. Given the passage of time since your admission to a Federal Indian Hospital, you might not have any documentation. Please do not let this deter you from submitting a Claim as submitting documents is optional.

Documentation (if available)

☐ **Please attach** a copy of any document that might help support your Claim.

Examples of documents that might help support your Claim:

- **Hospital admission confirmation** – Documents confirming your hospital admission (e.g., medical records with visit dates, treatments, doctor's notes).
- **Medical records / discharge summaries** – Medical records or discharge summaries from your hospital admission.
- **Appointment confirmation** – Appointment confirmation letters or other documents showing hospital or doctor appointments.
- **Other** – Any other documents that support your claim but do not fit the categories above.

Send only copies of documents (photocopy, scan, fax or photo) – do not send original documents.

Please write the Claimant's first and last name and date of birth (as entered in **Part 1A** of this Claim Form) clearly on every page of each copy you include. This will ensure that all documentation is matched to the correct Claim Form. Please make sure all copies are clear and easy to read.

PART 2B | Hospital Admission – Abuse/Harm Experienced (Required)

Use this section to describe the abuse/harm that you experienced while admitted at the Federal Indian Hospital (see the Hospital List in **Part 2** of this Claim Form). Please ensure that you provide all required information for your selected level and answer all required questions in order for your Claim Form to be considered complete.

Important:

- Do not include abuse/harm connected to medical treatment.
- Please note that you cannot combine or select multiple levels. Only select one level.
- If multiple levels apply to your experience, select the highest level which applies to you.

Step 1 – Choose one level that matches your experience (required)

Please carefully read the descriptions of all five levels of abuse/harm described in this Step and select the highest level of abuse/harm that best matches your experience. You will be asked to share your selected level in Step 2.

Important:
Once the level is submitted with your Claim Form, you cannot ask to be assessed at a higher level.

Level 1 | Compensation amount: $10,000

- Sexual comments or sexualized provocation; OR
- Unreasonable or disproportionate acts of discipline or punishment; OR
- One or more incidents of mocking, denigration (e.g., belittling or abusive language), or humiliation (e.g., shaming); OR
- Threats of violence or intimidating statements or gestures; OR
- One or more incidents of abuse, such as:
  - Unreasonable confinement unrelated to medical treatment and interventions; OR
  - Being forced to consume alcohol and/or illegal substances, excluding the administration of necessary medication including narcotics.

Level 2 | Compensation amount: $50,000

- One or more incidents of:
  - Nude photographs taken of the Claimant with no medical purpose (such as for medical treatment or interventions including X-rays); OR
  - Non-patients exposing their genitals or other private parts to the Claimant; OR
  - Touching genitals or other private parts (directly or through clothing), excluding touching for a medical purpose (e.g., with a thermometer, scope, or other medical device); OR
  - Fondling or kissing; OR
  - Simulated intercourse through clothing; OR
- One or more incidents of physical assault causing:
  - Minor impairment or disfigurement that was not permanent (e.g., loss of consciousness, broken bones, loss of or damage to teeth, black eye, bruise, abrasion, laceration, fracture) excluding extractions of teeth or minor impairment or disfigurement that is the result of medical treatment or interventions.

We recognize that recalling these experiences can be difficult. If you need mental health support, please call the Hope for Wellness Helpline at **1-855-242-3310** or visit **www.hopeforwellness.ca**.

PART 2B | Hospital Admission – Abuse/Harm Experienced (Required)

Level 3 | Compensation amount: $100,000

- One incident of:
  - Masturbation; OR
  - Oral or attempted oral intercourse; OR
  - Attempted penetration (including vaginal or anal, digital penetration or penetration with an object) excluding attempted penetration for a medical purpose (e.g., with a thermometer, scope, or other medical device); OR
- Recurring (pattern or repetitive) physical assaults causing:
  - Minor impairment or disfigurement that was not permanent (e.g., loss of consciousness, broken bones, loss of or damage to teeth, black eye, bruise, abrasion, laceration, fracture) excluding extractions of teeth or minor impairment or disfigurement that is the result of medical treatment or interventions.

Level 4 | Compensation amount: $150,000

- One incident of penetration:
  - Including vaginal or anal, digital penetration or penetration with an object) excluding penetration for a medical purpose (e.g., with a thermometer, scope, or other medical device); OR
- Two or more incidents of:
  - Attempted oral intercourse; OR
  - Attempted penetration (including vaginal or anal, digital attempted penetration or attempted penetration with an object) excluding attempted penetration for a medical purpose (e.g., with a thermometer, scope, or other medical device); OR
- One or more physical assaults causing permanent or long-term mental or physical impairment, injury, or disfigurement.

Level 5 | Compensation amount: $200,000

- Two or more incidents of:
  - Masturbation; OR
  - Oral intercourse; OR
  - Penetration (including vaginal or anal, digital penetration or penetration with an object) excluding penetration for a medical purpose (e.g., with a thermometer, scope, or other medical device); OR
- Any pregnancy resulting from an incident of sexual assault (including pregnancy that is interrupted by miscarriage or therapeutic abortion); OR
- One or more physical assaults causing permanent loss of mobility or brain injury.

Step 2 – Confirm your selected level in writing from the options above (1, 2, 3, 4 or 5) (required)

I select level: ☐

We recognize that recalling these experiences can be difficult. If you need mental health support, please call the Hope for Wellness Helpline at **1-855-242-3310** or visit **www.hopeforwellness.ca**.

PART 2B | Hospital Admission – Abuse/Harm Experienced (Required)

Step 3 – Age and consent declaration (required, if applicable)

We recognize that recalling these experiences can be difficult. If you are claiming that you were sexually abused and you were over the age of 18 when the sexual abuse occurred, this step is required to determine your eligibility under the Settlement Agreement.

☐ Please place an "X" in this box if you were over the age of 18 and incidents of a sexual nature were unwanted or you did not provide consent.

Step 4 – Provide details surrounding your experience (required)

- **Important:** Please read the instructions below carefully.

In this section, you will answer a series of questions that describe the specific abuse/harm you experienced while admitted in a Federal Indian Hospital. This information is necessary for the Claims Administrator to assess your eligibility to receive the compensation for the level of abuse/harm you indicated above, or to shed light on your experience so the Claims Administrator can adjust your compensation accordingly.

Instructions

1. There is space in the next pages to describe the abuse/harm you experienced related to one of the **33 Federal Indian Hospitals**. You may document up to three separate abuses/harms you experienced in the Federal Indian Hospitals in this Claim Form. Any additional abuse/harm experienced should be documented in **Appendix B**.
2. Please fill out all six questions related to each abuse/harm to the best of your ability.
3. Please write down as much as you remember about each abuse/harm you have experienced. The more detail you share, the better we can assess your Claim.
4. Please focus on abuse/harm you experienced while at the Federal Indian Hospital.

We recognize that recalling these experiences can be difficult. If you need mental health support, please call the Hope for Wellness Helpline at **1-855-242-3310** or visit **www.hopeforwellness.ca**.

PART 2B | Hospital Admission – Abuse/Harm Experienced (Required)

Abuse/Harm #1

1. **What was the abuse/harm that you experienced while admitted to a Federal Indian Hospital?** *Provide a brief description.*

2. **What was the name of the Federal Indian Hospital where you experienced abuse/harm?** *If you do not know the name, please provide the best description you can of the location.*

3. **Who was responsible for the abuse/harm?** *If you're not sure, provide the best description you can (example: a doctor, a nurse, another patient, or a visitor).*

4. **As best as you can remember, when did the abuse/harm occur?** *If you're not sure, you can provide your age when the abuse/harm occurred (example: I was 16 years old). You can also provide your best estimate as a range (example: sometime between 1971 and 1973 or when I was between 23 and 27 years old).*

5. **How many times did the abuse/harm happen to you?** *If you're not sure, you can provide a range (example: 4-5 times). You can also provide an answer that is not specific (example: many times or more than twice).*

6. **Please describe the impact that this abuse/harm has had on you.** *The impact of physical or sexual abuse could include black eyes, bruises, cuts, being knocked unconscious, broken bones or teeth, scars, pregnancy, complications from pregnancy and/or childbirth, long-term or permanent physical disability/injury/impairment, long-term or permanent mental disability/injury/impairment (for example, depression, anxiety, or post-traumatic stress disorder (PTSD)), permanent loss of mobility or brain injury.*

We recognize that recalling these experiences can be difficult. If you need mental health support, please call the Hope for Wellness Helpline at **1-855-242-3310** or visit **www.hopeforwellness.ca**.

PART 2B | Hospital Admission – Abuse/Harm Experienced (Required)

Abuse/Harm #2

1. **What was the abuse/harm that you experienced while admitted to a Federal Indian Hospital?** *Provide a brief description.*

2. **What was the name of the Federal Indian Hospital where you experienced abuse/harm?** *If you do not know the name, please provide the best description you can of the location.*

3. **Who was responsible for the abuse/harm?** *If you're not sure, provide the best description you can (example: a doctor, a nurse, another patient, or a visitor).*

4. **As best as you can remember, when did the abuse/harm occur?** *If you're not sure, you can provide your age when the abuse/harm occurred (example: I was 16 years old). You can also provide your best estimate as a range (example: sometime between 1971 and 1973 or when I was between 23 and 27 years old).*

5. **How many times did the abuse/harm happen to you?** *If you're not sure, you can provide a range (example: 4-5 times). You can also provide an answer that is not specific (example: many times or more than twice).*

6. **Please describe the impact that this abuse/harm has had on you.** *The impact of physical or sexual abuse could include black eyes, bruises, cuts, being knocked unconscious, broken bones or teeth, scars, pregnancy, complications from pregnancy and/or childbirth, long-term or permanent physical disability/injury/impairment, long-term or permanent mental disability/injury/impairment (for example, depression, anxiety, or post-traumatic stress disorder (PTSD)), permanent loss of mobility or brain injury.*

We recognize that recalling these experiences can be difficult. If you need mental health support, please call the Hope for Wellness Helpline at **1-855-242-3310** or visit **www.hopeforwellness.ca**.

PART 2B | Hospital Admission – Abuse/Harm Experienced (Required)

Abuse/Harm #3

1. **What was the abuse/harm that you experienced while admitted to a Federal Indian Hospital?** *Provide a brief description.*

2. **What was the name of the Federal Indian Hospital where you experienced abuse/harm?** *If you do not know the name, please provide the best description you can of the location.*

3. **Who was responsible for the abuse/harm?** *If you're not sure, provide the best description you can (example: a doctor, a nurse, another patient, or a visitor).*

4. **As best as you can remember, when did the abuse/harm occur?** *If you're not sure, you can provide your age when the abuse/harm occurred (example: I was 16 years old). You can also provide your best estimate as a range (example: sometime between 1971 and 1973 or when I was between 23 and 27 years old).*

5. **How many times did the abuse/harm happen to you?** *If you're not sure, you can provide a range (example: 4-5 times). You can also provide an answer that is not specific (example: many times or more than twice).*

6. **Please describe the impact that this abuse/harm has had on you.** *The impact of physical or sexual abuse could include black eyes, bruises, cuts, being knocked unconscious, broken bones or teeth, scars, pregnancy, complications from pregnancy and/or childbirth, long-term or permanent physical disability/injury/impairment, long-term or permanent mental disability/injury/impairment (for example, depression, anxiety, or post-traumatic stress disorder (PTSD)), permanent loss of mobility or brain injury.*

We recognize that recalling these experiences can be difficult. If you need mental health support, please call the Hope for Wellness Helpline at **1-855-242-3310** or visit **www.hopeforwellness.ca**.

PART 2B | Hospital Admission – Abuse/Harm Experienced (Required)

Additional details (optional)

You can share any additional details about the abuse/harm you experienced, if you feel comfortable. This section is entirely optional. We recognize that relating your experiences can be difficult and may bring up strong feelings. Please know that your experiences and your truth are respected here. You may choose to include information in your own words and in the way that feels right for you.

We recognize that recalling these experiences can be difficult. If you need mental health support, please call the Hope for Wellness Helpline at **1-855-242-3310** or visit **www.hopeforwellness.ca**.

PART 3 | Payment Details (Required)

If your Claim is approved for compensation, payment will be sent by direct deposit or cheque. Payments will only be issued after your Claim is approved by the Claims Administrator.

- **Important:** If you move after submitting this Claim Form, contact the Claims Administrator to update your address.

Option 1 – Direct Deposit

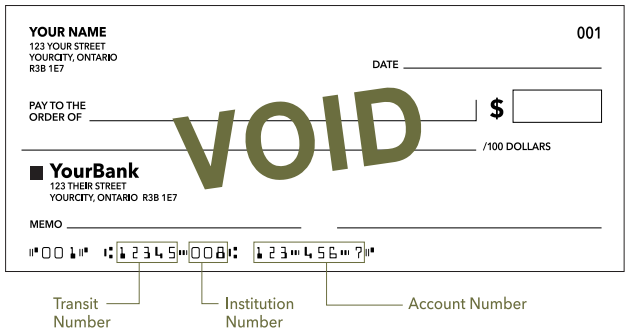
☐ Please select this option if you would like compensation by direct deposit.

Bank account information

Transit number

Institution number

Account number (7-12 digits)



To receive compensation by direct deposit, you need to meet the requirements listed to the right.

A compensation cheque will be mailed to you if any of the information is not provided, is incorrect, or the bank does not accept your direct deposit.

1. You have attached a void cheque or direct deposit form to this Claim Form, so we know where to send the payment.
2. The bank account is in the name of the person who will be paid the compensation. The bank account should be in the name of the Claimant, or if applicable, the Estate of the deceased Claimant.
3. The bank account is with a Canadian financial institution and in Canadian currency.
4. The banking information you provided is accurate. Once the payment is deposited, we can't get it back or make replacement payments. For example, if you provide a family member's banking information instead of your own, we can't get that payment back for you.

OR

Option 2 – Cheque

☐ Please select this option if you would like to receive compensation by cheque.

Note: If you are an Estate Representative, you will receive the compensation that the deceased Claimant would have been entitled to. If you open a bank account for the Estate, payment can be made directly into the bank account. If payment is made by cheque, it will be made out to the Estate of the deceased Claimant.

Note: Payments issued for a Claimant who is a Person Under Disability or represented by a Personal Representative will be made payable to the Claimant to the attention of the Personal Representative or Power of Attorney. There must be a bank account in the name of the Claimant for compensation to be issued, unless otherwise prescribed by the applicable Appointment Order.

END OF CLAIM FORM

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): / /

Appendix A | Any Additional Federal Indian Hospital Admission(s)

This Appendix should be used if you've experienced abuse/harm during more than one admission to a Federal Indian Hospital. That is, if you were admitted to the same hospital more than once and experienced abuse/harm each time and/or if you attended more than one Federal Indian Hospital and experienced abuse/harm each time.

Important:

- You do not need to record every admission to every Federal Indian Hospital you've been admitted to. You only need to record the admissions where you've experienced abuse/harm.
- Don't forget to enter the name of the hospital and the dates of admission so we know which hospital admission your answers apply to.
- If you have experienced abuse/harm at more than one additional hospital, please include extra pages labelled "Additional Hospital #2", "Additional Hospital #3", etc., and include your answers to questions 1-12.
- For each Federal Indian Hospital admission, answer the questions as best as you can. Example answers are provided as guidance only to assist you.
- Please provide any relevant documents you may have related to your admission to a Federal Indian Hospital. Given the passage of time since your admission to a Federal Indian Hospital, you might not have any documentation. Please do not let this deter you from submitting a Claim as submitting documents is optional.

Additional Hospital

Information about your admission (required)

For each Federal Indian Hospital admission, answer the following questions as best as you can. Please provide as much information as you are comfortable sharing. *Example answers are provided as guidance only to assist you.*

1. **Province/Territory.** *Example: Alberta.*

2. **What is the name of the hospital you were admitted to?** *Example: Charles Camsell Hospital.*

3. **Month (MM) / year (YYYY) admission began.** *Example: 03/1965.*

   /

4. **Month (MM) / year (YYYY) admission ended.** *Example: 06/1965.*

   /

5. **For how long were you admitted to the hospital?** *Example: 3 months.*

6. **What was the reason for your admission?** *Example: Tuberculosis treatment.*

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): ___ / ___ / ____

Appendix A | Any Additional Federal Indian Hospital Admission(s)

Additional Hospital continued

7. **Where did you live before being admitted to the hospital (including address if known)?** *Example: St. Mary's Indian Residential School.*

8. **Why did you go to this particular hospital (instead of another)?** *Example: It was the closest hospital to my community.*

9. **How did you get to and from the hospital at the beginning and end of your admittance?** *Example: By ship.*

10. **What are the names of any of the doctors, nurses, or other staff who assisted you?** *Example: Dr. Smith, Nurse Johnson.*

11. **What types of medical treatment did you receive?** *Example: Antibiotics, physical therapy.*

12. **Were you transferred to/from another hospital or medical facility before/after being admitted to the Federal Indian Hospital?** *Example: Transferred to a Tuberculosis (TB) Sanitorium after admission.*

Additional details (recommended)

This section is for you to share any other information about your admission at the Federal Indian Hospital for example other patients' names or a description of the hospital. Please fill in what you feel comfortable sharing. Do not include information about any eligible abuse/harm you may have experienced here (see **Appendix B** for details).

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): / /

Appendix B | Additional Details About Your Experience at a Federal Indian Hospital

Any additional abuse/harm you experienced at a Federal Indian Hospital documented in this Claim Form can be recorded below. Please ensure you answer all six questions related to the abuse/harm. If the space below is not sufficient, please include extra pages labelled "Abuse/Harm #5" and "Abuse/Harm #6" and include your answers to questions 1-6.

Additional Abuse/Harm

1. **What was the abuse/harm that you experienced while admitted to a Federal Indian Hospital?** *Provide a brief description.*

2. **What was the name of the Federal Indian Hospital where you experienced abuse/harm?** *If you do not know the name, please provide the best description you can of the location.*

3. **Who was responsible for the abuse/harm?** *If you're not sure, provide the best description you can (example: a doctor, a nurse, another patient, or a visitor).*

4. **As best as you can remember, when did the abuse/harm occur?** *If you're not sure, you can provide your age when the abuse/harm occurred (example: I was 16 years old). You can also provide your best estimate as a range (example: sometime between 1971 and 1973 or when I was between 23 and 27 years old).*

5. **How many times did the abuse/harm happen to you?** *If you're not sure, you can provide a range (example: 4-5 times). You can also provide an answer that is not specific (example: many times or more than twice).*

6. **Please describe the impact that this abuse/harm has had on you.** *The impact of physical or sexual abuse could include black eyes, bruises, cuts, being knocked unconscious, broken bones or teeth, scars, pregnancy, complications from pregnancy and/or childbirth, long-term or permanent physical disability/injury/impairment, long-term or permanent mental disability/injury/impairment (for example, depression, anxiety, or post-traumatic stress disorder (PTSD)), permanent loss of mobility or brain injury.*

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): ___ / ___ / ____

Appendix C | Deceased Claimant - Estate Representative (With or Without a Grant of Authority)

You must complete **Appendix C** if the Claimant passed away on or after January 25, 2016. Please refer to the **Estates Protocol** for further details related to the processing of Estate Claims.

An Estate Representative with a Grant of Authority (for example, a valid Will or court order) may submit a Claim Form. If there is no Grant of Authority, an Heir to a Claimant can submit a Claim Form.

Note:

- If you are the Estate Representative (with or without a Grant of Authority), enter your contact details below.
- If you are a newly appointed Estate Representative (with or without a Grant of Authority) of a Claimant who has passed away and has already submitted a Claim Form, please contact the Claims Administrator at **1-888-592-9101** or visit the FAQs online at **www.ihsettlement.ca/faq**.
- **Important:** If you need to change your contact information (for example: your mailing address, email, or phone number), please contact the Claims Administrator at **1-888-592-9101**.

Your name (required)

Your name must match your government-issued identification (ID).

First name:

Middle name (if applicable):

Last name:

Identification (required)

☐ **Please attach** a copy of your Federal or Provincial government-issued ID to your application.

Examples of accepted ID:

- Certificate of Indian Status (Status Card)
- Inuit Beneficiary Card
- Métis Citizenship Card
- Passport
- Driver's License
- Provincial/Territorial Photocards
- Health Card

Your employer/organization (if applicable)

Send only copies of documents (photocopy, scan, fax or photo) – do not send original documents.

Please write the Claimant's first and last name and date of birth (as entered in **Part 1A** of this Claim Form) clearly on every page of each copy you include. This will ensure that all documentation is matched to the correct Claim Form. Please make sure all copies are clear and easy to read.

Claimant full name (required): Claimant date of birth (required) (DD/MM/YYYY): / /

Appendix C | Deceased Claimant - Estate Representative (With or Without a Grant of Authority)

Your mailing address (required)

Street number Street name

Unit P.O. Box (if applicable)

City / Town / Community Postal Code

Province / Territory Country

C/O Name (if applicable)

If your mailing address is a facility (such as a correctional or medical facility) or a public place (such as a hotel or Friendship Centre), or if you are staying with a friend or family member, please include the name.

Your email address (if available):

Your telephone number (recommended): - - Ext.

Please select the phone number you provided: ☐ Home ☐ Mobile ☐ Work ☐ Other:

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): ___ / ___ / ____

Appendix C | Deceased Claimant - Estate Representative (With or Without a Grant of Authority)

Supporting documentation (required)

Please select the category that applies to you and provide copies of the required document(s) with your Claim Form and Claimant's Death Certificate as proof of your authority to act as Estate Representative.

Check the category that applies		Required document(s)
☐ **Grant of Authority** (All Provinces and Territories except for Québec)	**Will** – You are named as Estate Representative in a valid Will pursuant to applicable federal, provincial, or territorial legislation.	- Death Certificate; AND - Will signed by the deceased and at least two witnesses; OR - Holographic Will, drafted and signed only by the testator (not valid in British Columbia or Prince Edward Island).
	Other Grant of Authority – You have been officially appointed as Estate Executor or Administrator by a court or government authority.	- Death Certificate; AND - Grant of Probate; OR - Appointment of Trustee; OR - Other official Grant of Authority document (e.g. Letters of Administration from INAC, ISC or CIRNAC).
OR		
☐ **Grant of Authority** (Québec)	**Will** – You are named as Liquidator in a valid Will.	- Death Certificate; AND - Notarial Will; OR - Holographic or witnessed Will accompanied by the homologation (probate) judgment.
	Appointment of Liquidator – You are designated as the Liquidator by the Heirs to administer the Estate.	- Death Certificate; AND - Appointment of Liquidator; AND - Certificate of Will Search from both the **Chambre des Notaires and the Barreau du Québec**; AND - Revenu Québec forms **LM-14-V** or **LM-14.1-V**; AND - Revenu Québec form **MR-14.A-V**.
OR		
☐ **Heir** (Only if NONE of the above exist, i.e., no Grant of Authority, an Heir may submit a Claim Form)	**Heir** – The deceased did not have a valid Will, and no Grant of Authority by a court or government exists. You are an Heir (for example, spouse, common-law partner, child, grandchild, parent, sibling, or grandparent).	- Death Certificate; AND - Document(s) showing proof of your relationship to the deceased (e.g., Long Form Birth Certificate, Marriage Certificate) - ***Note:*** *For "Indians" as defined under the Indian Act, who lived on reserve, the Indian Act applies in all provinces and territories including Québec upon intestacy.*

Send only copies of documents (photocopy, scan, fax or photo) – do not send original documents.

Please write the Claimant's first and last name and date of birth (as entered in **Part 1A** of this Claim Form) clearly on every page of each copy you include. This will ensure that all documentation is matched to the correct Claim Form. Please make sure all copies are clear and easy to read.

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

Appendix C | Deceased Claimant - Estate Representative (With or Without a Grant of Authority)

Heir Claim Only

Important: Only fill out the rest of this Appendix (C) if you are applying as the highest priority Heir.
Only fill out the remainder of this section if the Claimant passed away and an Administrator/Executor/Trustee/Liquidator was not appointed for their Estate. The priority of Heirs is determined by identifying the living Heir with the highest priority based on the list in Step 2 on the next page.

Step 1 – Place an "X" in this box if the statement is true (required)

☐ To the best of your knowledge, there is no Grant of Authority in place (such as a Will or Letter of Administration from Indigenous Services Canada). The deceased did not leave a Will, and no Executor, Administrator, Liquidator, or Trustee has been appointed by the court or the Government of Canada or a provincial/territorial government or legislation. All reasonable efforts have been made to locate a Will or other Grant of Authority.

Step 2a – Identify your relationship to the deceased Claimant (required)

The priority of Heirs is determined by identifying the living Heir with the highest priority based on the list below.

Select only one category of relation

1. ☐ **Surviving spouse** (legally married or common-law) at the time of Claimant's death		
2. ☐ **Child** (or child's legal guardian)	3. ☐ **Grandchild** (or grandchild's legal guardian)	4. ☐ **Parent**
5. ☐ **Sibling** (brother/sister)	6. ☐ **Child of sibling** (niece/nephew)	7. ☐ **Other**

Step 2b – Place an "X" in this box if the statement is true (required)

☐ I declare that to the best of my knowledge and belief there are no living family members who are a higher priority Heir Claimant than me.

Step 2c – Written consent from other higher priority Heir(s) (if applicable)

Documentation (if applicable)

☐ **Please attach** a copy of any written consents from the non-applying higher priority Heir(s).

If there are living family member(s) who are higher priority Heir(s), please provide written consent(s) of the non-applying higher-priority Heir(s).

Send only copies of documents (photocopy, scan, fax or photo) – do not send original documents.
Please write the Claimant's first and last name and date of birth (as entered in **Part 1A** of this Claim Form) clearly on every page of each copy you include. This will ensure that all documentation is matched to the correct Claim Form. Please make sure all copies are clear and easy to read.

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): ___ / ___ / ____

Appendix C | Deceased Claimant - Estate Representative (With or Without a Grant of Authority)

Heir Claim Only

Step 3 – Please provide proof of your relationship to the deceased Claimant if available If proof is not available, provide an Attestation / Sworn Declaration (required)

Documentation (if available)

☐ **Please attach** a copy of any document that might help confirm your relationship to the deceased. Please do not submit documents such as family photographs, letters or unofficial records.

Examples of documentation:

- **Marriage** – Record of Solemnization / Marriage Certificate
- **Parent-child relationship** – Birth Certificate of the child
- **Parent and legally adopted child** – Adoption Order
- **Other** (describe):

- **Attestation / Sworn Declaration**

- **Important:** Heir Claims will only be processed at the end of the Claims Period and the Claims Administrator will contact you to obtain more information later. The Claims Administrator can disclose identities of competing Heirs to each other where applicable.

Send only copies of documents (photocopy, scan, fax or photo) – do not send original documents.

Please write the Claimant's first and last name and date of birth (as entered in **Part 1A** of this Claim Form) clearly on every page of each copy you include. This will ensure that all documentation is matched to the correct Claim Form. Please make sure all copies are clear and easy to read.

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): / /

Appendix C | Deceased Claimant - Estate Representative (With or Without a Grant of Authority)

Heir Claim Only

Sworn Declaration

You must complete the following Sworn Declaration only if you are an Heir and you do not have the supporting documentation to prove your relationship to the deceased (i.e. Marriage Certificate, Birth Certificate, etc.).

A Sworn Declaration is a statement signed by the Claimant and any one of the following Guarantors, with Titles:

- Notary Public or Commissioner of Oaths including Northern Villages' Secretary Treasurer
- Elected Official or Community leader (e.g. Chief, Councilor, Inuit Community Leader)
- Other Professional (e.g. Lawyer, Doctor/Physician, Accountant (CPA), Police Officer)

Sworn Declaration by Heir:

I declare that the information I have provided regarding the relationship to the deceased is true to the best of my knowledge.

SIGN

Heir first name (printed) | Heir last name (printed)

Signature of Heir (required) | Day (DD) / Month (MM) / Year (YYYY)

Above declaration must be witnessed by a Guarantor (virtually or in person) in accordance with the applicable provincial/territorial requirements**.** The Guarantor only needs to see the Claimant sign this page. As Guarantor, you are not required to read or verify the accuracy of the events described in this Claim Form. **Guarantor must complete all fields below.**

Guarantor first name | Guarantor last name

Guarantor title | Guarantor position | Guarantor employer/organization

Street number | Street name | Unit

City / Town / Community | Postal Code

Province / Territory | Country

Telephone number | Email address (if available)

SIGN

Signature of Guarantor (required) | Day (DD) / Month (MM) / Year (YYYY)

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): ___ / ___ / ____

Appendix D | Personal Representative for a Claimant who is a Person Under Disability

Only complete this section if you are a Personal Representative* of a Claimant who is a Person Under Disability*. If you are applying for a deceased Claimant, complete **Appendix C** instead.

- **Note:** If you are a newly appointed Representative of a Claimant who is a Person Under Disability and has already submitted a Claim Form, please contact the Claims Administrator at **1-888-592-9101** or visit the FAQs online at **www.ihsettlement.ca/faq**.
- **Important:** If you need to change your contact information (for example: your mailing address, email, or phone number), please contact the Claims Administrator at **1-888-592-9101**.

* Defined in the FAQs.

Your name (required)

Your name must match your government-issued identification (ID).

First name:

Middle name (if applicable):

Last name:

Identification (required)

☐ **Please attach** a copy of your Federal or Provincial government-issued ID to your application.

Examples of accepted ID:

- Certificate of Indian Status (Status Card)
- Inuit Beneficiary Card
- Métis Citizenship Card
- Passport
- Driver's License
- Provincial/Territorial Photocards
- Health Card

Your employer/organization (if applicable)

Send only copies of documents (photocopy, scan, fax or photo) – do not send original documents.

Please write the Claimant's first and last name and date of birth (as entered in **Part 1A** of this Claim Form) clearly on every page of each copy you include. This will ensure that all documentation is matched to the correct Claim Form. Please make sure all copies are clear and easy to read.

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): / /

Appendix D | Personal Representative for a Claimant who is a Person Under Disability

Your mailing address (required)

Street number | Street name

Unit | P.O. Box (if applicable)

City / Town / Community | Postal Code

Province / Territory | Country

C/O Name (if applicable)

If your mailing address is a facility (such as a correctional or medical facility) or a public place (such as a hotel or Friendship Centre), or if you are staying with a friend or family member, please include the name.

Your email address (if available):

Your telephone number (recommended): - - Ext.

Please select the phone number you provided: ☐ Home ☐ Mobile ☐ Work ☐ Other:

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): ___ / ___ / ____

Appendix D | Personal Representative for a Claimant who is a Person Under Disability

Supporting documentation (required)

Please select the category that applies to you by placing an "X" in the box and provide copies of the required document(s) with this Claim Form to show that you are the Claimant's Personal Representative or Power of Attorney.

Check the category that applies		Required document(s)
☐ **Personal Representative**	You have the legal authority to act on behalf of the Claimant who cannot manage their own legal, financial or personal matters due to a disability.	- Provincial/Territorial Appointment Order (including appointment of Public Guardian and Trustee); OR - Federal Appointment Order (e.g., Indigenous Services Canada Administrator for Property); OR - Letters of Appointment for property/finances; OR - Court Order appointing a Personal Representative.
OR		
☐ **Power of Attorney (POA)**	You have the legal authority to manage the Claimant's financial and property matters.	- Power of Attorney Document signed by the grantor with two witnesses; AND - Relevant court order (if POA was contested or clarified by a court).

Send only copies of documents (photocopy, scan, fax or photo) – do not send original documents.

Please write the Claimant's first and last name and date of birth (as entered in **Part 1A** of this Claim Form) clearly on every page of each copy you include. This will ensure that all documentation is matched to the correct Claim Form. Please make sure all copies are clear and easy to read.

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): ___ / ___ / ____

Appendix E | Individual Legal Counsel

As Individual Legal Counsel, you must enclose the Retainer Agreement signed and dated by you and the Claimant or the Estate/Personal Representative applying on the Claimant's behalf. Please refer to the Individual Legal Fees Protocol for further details related to the processing of payment of legal fees.

Your Retainer must indicate that the legal services provided are for the purpose of assisting the Claimant with their Claim under the Settlement Agreement for the Federal Indian Hospitals Class Action.

Important:

- Individual Legal Counsel must have submitted a valid Retainer Agreement in line with the Individual Legal Fees Protocol and be a practising lawyer in good standing in a Canadian province or territory.
- If you move, change your email address or phone number, please provide your new contact information to the Claims Administrator at 1-888-592-9101.

- **Note:** In order to receive payment of prescribed legal fees, you will also need to complete and return the Individual Legal Counsel Payment Request Form.

Your name (required)

Your name must match the name associated with your Law Society Number / Barreau du Québec member number.

First name:

Middle name (if applicable):

Last name:

Organization information (required)

Your law organization/firm

Province/Territory

Law Society Number / Barreau du Québec member number

Class Counsel disclosure

Aside from your capacity as Individual Legal Counsel for the Claimant or the person applying on their behalf, are you Class Counsel?

☐ No ☐ Yes →

If yes, which firm?

☐ Koskie Minsky LLP ☐ Merchant Law Group LLP

☐ Cooper Regel LLP ☐ Klein Lawyers LLP

Claimant full name (required): | Claimant date of birth (required) (DD/MM/YYYY): / /

Appendix E | Individual Legal Counsel

Your mailing address (required)

Street number | Street name

Unit | P.O. Box (if applicable)

City / Town / Community | Postal Code

Province / Territory | Country

C/O Name (if applicable)

Your email address (required):

Your telephone number (required): - - Ext.

Appendix F | Completed Claim Form Checklist

Review this checklist and complete all the steps to help ensure that your Claim is processed as efficiently as possible.

Please complete these final steps before submitting your Claim

Step	What is needed from you
☐ **Step 1**	**Gather your information** • Have your government-issued ID available. • Collect all supporting documents that apply to your role (see Step 3). • If your contact information (including your name) changes after you submit your Claim you must contact the Claims Administrator to update your contact information.
☐ **Step 2**	**Complete the Claim Form** • Fill out the Claim Form fully. • Answer all required questions clearly and completely.
☐ **Step 3**	**Attach required supporting documents (do not send originals - only clear copies)** • Government-issued ID. • Proof of legal name change, if applicable. • Federal Indian Hospital documents (e.g., referrals, confirmations, hospital records). • All documents relevant to your Claim: – **If the Claimant is deceased:** – *Death Certificate, plus one of the following;* – *Valid Will (signed and witnessed) or Grant of Authority or Québec Succession Documents or proof of relationship/attestation (if Heir);* – *If Heir, confirm no Will or Grant of Authority exists and specify your relationship to the Deceased Claimant.* – **If Claimant is a Person Under Disability with a Personal Representative:** – *POA Document, Court Order or Appointment Letters.* – **Legal Counsel:** – *Retainer Agreement;* – *Full Legal Counsel details (name, firm, law society number, province/territory);*
☐ **Step 4**	**Review the Claim Form and supporting documents** • Double-check that all sections of the Claim Form are complete. • Confirm that clear copies of all required supporting documents are attached.
☐ **Step 5**	**Make copies** • Make and retain copies of the completed Claim Form and all documents for your records.