

Canadian Thalidomide Survivors Support Program Extraordinary Medical Assistance Fund (“EMAF”) Appeal Form

Instructions

The attached Canadian Thalidomide Survivors Support Program (“CTSSP”) EMAF Appeal form is to be used to appeal the decision of the CTSSP Administrator concerning your request for funding from the Extraordinary Medical Assistance Fund (“EMAF”).

You are allowed **one** appeal for each EMAF Application you have submitted.

The appeal is to be in writing only. Your appeal will be reviewed by an independent Appeal Assessor at Epiq Class Action Services. Their decision will be final. There will be no further right of appeal.

Only the Thalidomide Survivor or his/her legally authorized Personal Representative may submit an appeal on behalf of the Survivor.

Please read all questions and requests for information carefully before answering. Incomplete information may lead to your appeal being delayed or denied.

Please consult the following resource documents for more information:

- [Comprehensive EMAF Guide](#)
- [EMAF Quick Reference Guide](#)
- [Frequently Asked Questions](#)

Step 1 - Personal Information:

Please review and complete Section 1: Thalidomide Survivor Contact Information.

If you are a legally authorized Personal Representative submitting the appeal on behalf of the Thalidomide Survivor or if you provided assistance with the form, you must also complete Section 2: Person who helped complete this form. If proof of a right to act on behalf of the Thalidomide Survivor was not previously provided or if the identity of the Personal Representative has changed, please submit proof immediately.

Step 2 – Details of your Appeal

Please complete Section 3 – Reason for Appeal. Please explain the reason(s) why your Appeal should be allowed. If you are a Personal Representative, please list the information as it pertains to the Thalidomide Survivor.

You may include additional supporting documentation, not previously submitted, to support your Appeal.

QUESTIONS? NEED HELP?

1-877-507-7706 • 1-877-627-7027 (TTY) • www.tsspcanada.ca

Step 3 – Submit the form:

Please review all information in the Appeal form and make a copy for your records before you send it. Send the original form and any supporting documentation to:

Canada Thalidomide Survivors Support Program
PO Box 507 STN B
Ottawa, ON, K1P 5P6
info@tsspcanada.ca; Fax: 1-866-262-0816

DEADLINE TO SUBMIT YOUR APPEAL

45 days from the date of your Decision Letter regarding your request for EMAF funding.

Next Steps:

You will receive an Acknowledgement letter by mail or email once your Appeal form is received. If we have any questions about your Appeal form, we will contact you by telephone, mail and/or email so it is important to keep us informed of any changes of address or telephone numbers by calling 1-877-507-7706 or 1-877-627-7027 (TTY), or by mail at the address above, or by email at info@tsspcanada.ca.

Your appeal will be assessed within 35 calendar days of receipt by the Administrator. You will receive a decision letter concerning your appeal once your form has been reviewed by the Appeal Assessor. **The Decision from the Appeal Assessor will be final. There will be no further right of appeal.**

QUESTIONS? NEED HELP?

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Canadian Thalidomide Survivors Support Program EMAF Appeal Form

Privacy Statement:

The information requested in this Canadian Thalidomide Survivors Support Program EMAF Appeal form is being collected, used and retained by the Canadian Thalidomide Survivors Support Program Administrator (“Administrator”) and its Agents for the purpose of operating and administering the Canada Thalidomide Survivors Support Program Administration pursuant to the *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5 (“PIPEDA”). The information will be provided to the Government of Canada in order to facilitate the administration of the Canada Thalidomide Survivors Support Program. Personal information is protected under federal legislation, including PIPEDA and the *Privacy Act*, and personal information may be used or disclosed in accordance with applicable legislation. You have the right to request access to your personal information. To do so, call 1-877-507-7706 or 1-877-627-7027 (TTY).

| Section 1: Thalidomide Survivor Contact Information | |
|--|--|
| Language Preference: | <input type="checkbox"/> English <input type="checkbox"/> French |
| Communication Preference: | <input type="checkbox"/> Mail <input type="checkbox"/> Email * |
| First Name: | |
| Middle Name(s): | |
| Last Name: | |
| Date of Birth (mm/dd/yyyy): | |
| Sex at Birth: | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Mailing Address: | |
| City/Town: | |
| Province/Territory/State/Country: | |
| Postal Code/Zip Code: | |
| Primary Telephone Number: | () – |
| Alternate Telephone Number: | () – |
| Email Address *: | |

QUESTIONS? NEED HELP?

1-877-507-7706 • 1-877-627-7027 (TTY) • www.tsspcanada.ca

| Section 2: Person who helped complete this form | |
|--|--|
| <input type="checkbox"/> Same as Section 1 (If this box checked no need to complete Section 2 boxes below) | |
| First Name: | |
| Last Name: | |
| Email Address or Phone Number: | |
| Relationship to Survivor | |

| Section 3: Reason for Appeal |
|--|
| In the space below, please explain the reason(s) why you are appealing the decision of the Administrator concerning your request for EMAF funding. |
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Section 4: Declaration and Signature

Section 4 must be completed by the Thalidomide Survivor or the Personal Representative with the legal authority to act on behalf of the Survivor. Please read the following declaration carefully before signing.

Declaration: I have completed the Canadian Thalidomide Survivors Support Program EMAF Appeal form and I understand that an Appeal Reviewer at Epiq Class Action Services will be reviewing my appeal. I further understand that the information provided in this form and any additional supporting documentation included will be used to assess my appeal and that the decision of the Appeal Reviewer will be final.

I agree to the sharing of my personal information, including but not limited to my contact information, with the Administrator, the Government of Canada and necessary authorized third parties, only for the purpose of processing my appeal.

By signing below, I indicate my agreement to the contents of this Declaration.

Thalidomide Survivor/Personal Representative:

Print Name: _____

Signature: _____

Date: _____
(mm/dd/yyyy)

**Canadian Thalidomide Survivors Support Program
EMAF Appeal Form**

Please make sure the following have been included with your EMAF Appeal form when returning it to the Administrator:

- Supporting documentation not previously submitted with EMAF application, if applicable.
- Signed and dated Declaration for Claimant/Personal Representative in Section 4.

Please return the completed Canadian Thalidomide Survivors Support Program EMAF Appeal form to the Administrator **by email or mail postmarked** in the province or territory where the Survivor resides **within 45 calendar days of the date of the decision letter regarding your request for EMAF funding:**

Canadian Thalidomide Survivors Support Program
PO Box 507 STN B
Ottawa, ON, K1P 5P6
info@tsspcanada.ca; Fax: 1-866-262-0816