Canadian Thalidomide Survivors Support Program
Appeal of Extraordinary Medical Assistance Fund (‘EMAF”)

Instructions

The attached Canadian Thalidomide Survivors Support Program (“CTSSP”) Appeal form is to be used to appeal the decision of the CTSSP Administrator in regard to 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 Reviewer 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.

Step 1 - Personal Information:

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

If you are a legally appointed Personal Representative submitting the appeal on behalf of the Thalidomide Survivor, you must also complete Section 2: Legally Appointed Personal Representative Information. 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.

If someone helped you complete this form, please complete Section 3: Person who helped complete this form.

Step 2 – Details of your Appeal

Please complete Section 4 – 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. If supporting documentation is provided, please write the Thalidomide Survivor’s First and Last Name at the top of each additional page submitted.

Step 3 – Enclose Government Issued Identification and Sign the form:

Please review and complete Sections 5 and 6. If you are a Personal Representative, please sign and date the form and indicate that you are the Personal Representative.

Step 4 – 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: 1-888-842-1332

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 once your Appeal form is received to let you know that we received it. If we have any questions about your Appeal form, we will contact you by telephone and/or mail so it is important to keep us informed of any changes of address or telephone numbers by calling 1-866-343-1858 or 1-877-627-7027 (TTY), or by mail at the address above, or by email to info@tsspcanada.ca.

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

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:	☐ English ☐ French
Communication Preference:	☐ Mail ☐ Email
Sex at Birth:	☐ Male ☐ Female
Gender Identity:	☐ Male ☐ Female ☐ Other: _____________
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er ☐ Other (specify): _________________
First Name:	
Middle Name(s):	
Last Name:	
Date of Birth (mm/dd/yyyy):	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
Alternate Telephone Number:	( ) –
Email Address:	

Section 2: Legally Appointed Personal Representative Information **(Leave this section blank if the Survivor does not have a Legally Appointed Personal Representative)**	
This section is to be completed **only** if you have been **legally** appointed to administer the Survivor's affairs. You MUST provide proof of your authority to act as the Personal Representative of the Thalidomide Survivor. Please complete all boxes in both Section 1 on the previous page for the Survivor and Section 2 below for yourself.	
I have enclosed a **certified true** photocopy of one (1) of:	Please check (✓) the applicable box: ☐ Authority to Act ☐ Court Order ☐ Other: ______________________________ ☐ Authority to Act was previously submitted to the Administrator and has not changed (If this box is checked, no need to resend Authority to Act).
First Name:	
Last Name:	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
Alternate Telephone Number:	( ) –
Email Address:	
Relationship to Survivor	

Section 3: Person who helped complete this form ☐ **Same as Section 2 (If this box checked, no need to complete Section 3 boxes below)**	
First Name:	
Last Name:	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
Alternate Telephone Number:	( ) –
Email Address:	
Relationship to Survivor	

Section 4: Reason for Appeal

In the space below, please explain the reason(s) why you are appealing the decision of the Administrator in regard to your request for EMAF funding.

Section 5: Photo Identification and Privacy

To protect your privacy and to help confirm your identity when receiving documents from you, proof of identification is required by **ALL** eligible Survivors whenever a new form is submitted. Legally appointed Personal Representatives must provide identification for **both** the Survivor and the Personal Representative.

Please submit a photocopy of one (1) of the following government issued pieces of identification for proof of identity purposes. The identification **must include your date of birth**:

- Birth Certificate
- Baptismal Certificate
- Valid Provincial Driver's License
- Valid Provincial Photo ID Card (must include date of birth)
- Valid Canadian Passport

Section 6: Declaration and Signature

Section 6 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 there with 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)

All Thalidomide Survivors or legally appointed Personal Representatives must sign or sign with a mark in Section 6 in the presence of a witness who may be a relative. The witness must complete the Witness information below and sign the Witness Declaration on the next page.

Witness' First Name	Witness' Last Name

City/Town	Province/Territory/State	Country

Relationship to Thalidomide Survivor/Personal Representative

Witness Declaration: I have witnessed the signature or mark of the Thalidomide Survivor or legally appointed Personal Representative. Where the Thalidomide Survivor or legally appointed Personal Representative signed with a mark, I have read the content of this Canadian Thalidomide Survivors Support Program EMAF Appeal form to the Thalidomide Survivor and/or his/her Personal Representative, who signed with a mark, who understands and confirms the information.

Print Name: ____

Signature: ____

Date: ________________________
(mm/dd/yyyy)

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

- ☐ Proof of identification for Survivor
- ☐ Proof of identification for legally Authorized Representative (if applicable)
- ☐ Certified true copy of their authority to act on behalf of the Survivor (if applicable)
- ☐ Signed and dated Declaration for Claimant/Personal Representative in Section 6
- ☐ Completed, signed, and dated Witness section by Witness in Section 6

Please return the completed Canadian Thalidomide Survivors Support Program EMAF Appeal form to the Administrator **by 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: 1-888-842-1332