Paxil® and Paxil CR™
National Class Action Settlement

Complete, Sign and Submit by the Claims Bar Deadline by January 14, 2025.

1. If you were born with one or more congenital malformations to a mother who was prescribed Paxil® or Paxil CR™ for use in pregnancy, and used Paxil® or Paxil CR™ during the pregnancy or are the litigation or other guardian of the child, please provide the following information:

_____ _____ _____
First Name (Child) MI Last Name (Child)

_____/_____/_____ _____
DOB (dd/mm/yyyy) Social Insurance Number

_____
Address

_____ _____ _____
City Province Postal Code

_____ _____
Best Contact Number Email

2. If you are the mother of a child who was diagnosed with one or more congenital malformations after you were prescribed Paxil® or Paxil CR™ and you used either drug during the pregnancy, please provide the following information:

_____ _____ _____
First Name (Mother) MI Last Name (Mother)

_____/_____/_____ _____
DOB (dd/mm/yyyy) Social Insurance Number

_____
Address

_____ _____ _____
City Province Postal Code

_____ _____
Best Contact Number Email

3. Provide details of when you were prescribed Paxil® and Paxil CR™, when Paxil® and Paxil CR™ were dispensed and when you ingested Paxil® and Paxil CR™. Please provide records supporting the prescription or dispensation of Paxil® and Paxil CR™.

   Date Started: _____ Date Stopped: _____

4. Provide the date that your child who is making a Claim for a congenital malformation was born:

   _____

5. Provide the date of the commencement of your last menstrual period prior to the period of pregnancy:

   _____

6. Select for the congenital malformation(s) for which the Claim is made:

Malformation	Specific Injuries
☐ Cardiac	Structural cardiac congenital malformations, including: • atrial septal defect excluding patent foramen ovale • atrioventricular septal defect • coarctation of the aorta • transposition of the great vessels • hypoplastic left heart syndrome • pulmonary atresia • pulmonary stenosis • tetralogy of fallot • total anomalous pulmonary venous return • tricuspid atresia • truncus arteriosus • ventricular septal defect
☐ Craniofacial	• cleft lip and/or palate • craniosynostosis
☐ Neural tube	• anencephaly • spina bifida • encephalocele
☐ Abdominal	• gastroschisis • omphalocele • diaphragmatic hernia
☐ Skeletal	• club foot
☐ Urinary / genital	• undescended testes • hypospadias

7. Provide the name and address for any physician, hospital, or other healthcare professional or institution who treated the child for any condition listed above, with dates of treatment if known:

Provider	**Address**	**Dates of Treatment**

8. Has the child had surgery for any of the conditions listed above?

☐ Yes ☐ No

i. If the child has had surger(ies) please list below the type of surgery, hospital and date.

Type of Surgery	Facility/Hospital	Dates of Surgeries

9. Describe and provide supporting documentation regarding the likelihood of future medical interventions, if any, arising from the congenital malformation:

10. Describe and providing supporting documentation, regarding any vocational impairment, if any, arising from the congenital malformation.

11. Describe and provide supporting documentation which speaks to the likelihood of potential future complications, if any, arising from the congenital malformation.

12. The undersigned hereby consent(s) to the disclosure of the information contained herein to the extent necessary to process this Claim for Compensatory Benefits. Each person signing below agrees to cooperate with the Claims Administrator and Claims Officer and to provide any necessary medical record authorizations and releases for the Claims Officer to gather information needed to substantiate or audit the Claim. Each person signing below acknowledges and understands that this *Claim Form* is an official Court document approved by the Court that presides over the settlement, and that submitting it to the Claims Officer is equivalent to filing it with a court. After reviewing the information which has been supplied on this form, each person declares under penalty of perjury that the information provided in this form is true and correct to the best of his/her knowledge, information and belief.

Signature of Claimant Child (if an adult) (dd/mm/yyyy)

Signature of Mother or Litigation or Guardian (dd/mm/yyyy)

Complete, Sign and Submit your Claim Form and supporting documentation

by the Claims Bar Deadline of January 14, 2025.

Claim Forms may be submitted by one of the following methods:

i. E-mail: claims@trilogyclassactions.ca
ii. Fax : (416) 342-1761
iii. Postal mail: **Paxil Birth Defects Class Action**
c/o Trilogy Class Action Services
117 Queen Street, P.O. Box 1000,
Niagara-on-the-Lake, Ontario
L0S 1J0
Tel: (877) 400-1211

For more information and updates regarding the class action, or to view the Court documentation, please visit the website at **https://www.paxilbirthdefectsclassaction.ca/.**