« ACTION-AUTONOMIE » LE COLLECTIF POUR LA DÉFENSE DES DROITS EN SANTÉ MENTALE et al. C. CENTRE INTÉGRÉ DE SANTÉ ET DE SERVICES SOCIAUX DE LA MONTÉRÉGIE-CENTRE et al. (C.S.M. No. 500-06-001109-202)

Must be postmarked no later than August 10, 2025

Claim Form

SETTLEMENT OF THE CLASS ACTION *ACTION-AUTONOMIE ET AL. C. CENTRE INTÉGÉR DE SANTÉ ET DE SERVICES SOCIAUX DE LA MONTÉRÉGIE-CENTRE ET AL.* FOR PREVENTIVE CONFINEMENT PERIODS – INSTRUCTIONS FOR CLAIMANTS

This class action concerns people who have been placed under preventive confinement for more than seventy-two (72) hours, without judicial authorization and subject to a legal extension of confinement, in a Quebec hospital between January 1st, 2015 and November 4th, 2024.

The deadline for submitting a claim is August 10, 2025.

Claim forms can be submitted to the Claims Administrator online at gardepreventive@proactio.ca or filed online via the online claim form at Proactio.ca/gardepreventive. For paper claims, claim forms must be postmarked no later than August 10, 2025 and sent to the following address:

Proactio
Class action – Preventive confinement
600 de la Gauchetière West, suite 2000
Montreal (QC) H3B 4L8

If you require assistance or advice in completing the claim form, you may retain the services of a lawyer at your own expense or contact the group's lawyers, at no cost, at (514) 253-8044. **Claimants who retain the services of lawyers or mandataries to complete their claim form are solely responsible for the fees and expenses of such lawyers or mandataries.**

Claimants (or their attorneys or agents) **must** notify the Claims Administrator **in writing** of any changes or corrections to their name, address, telephone number or legal representation.

Please keep copies of all documents you send as part of the claims process.

Please note that it may take several weeks or more to obtain the medical documents to support your application.

Please start the claims **process now**.

If you are applying on behalf of an estate or incapable person, you must provide all supporting documents authorizing you to represent the estate or incapable person.

DECLARATION OF CONFIDENTIALITY

Claimants' personal information is collected, used and retained by the group's Lawyers and the Claims Administrator in accordance with applicable privacy laws and regulations:

- for the purposes of operating and administering the Quebec Class Action Settlement ***Action-Autonomie et al. c. Centre intégré de santé et de services sociaux de la Montérégie-Centre et al.*** (« Settlement Agreement »);
- to assess and review the Claimant's eligibility under the Settlement Agreement; and
- are strictly private and confidential and will not be disclosed without the express written consent of the claimant, except as provided in the Settlement and Compensation Agreement

SECTION 1 — Claimant identification

I am submitting a claim on behalf of the following claimant:

Applicant's first name | Initial | Last name

Current address

City | Province | Postal code

Home Phone | Business Phone

E-mail

Provincial health insurance card number

MM / DD / YYYY
Date of birth

MM / DD / YYYY
For estate claims: Date of death

The Claimant is :

☐ **1. Myself**

Documents required for identification:

- Government-issued identification, e.g. photocopy of health insurance card, driver's license, passport or birth certificate

☐ **2. An incapable person or a minor (fill in sections 2)**

Documents required for identification:

- Proof of government identity of represented claimant
- Proof of representative's government identity
- Proof of your right to act for the claimant (i.e. power of attorney, etc.)

☐ **3. A deceased person (fill in sections 2)**

Documents required for identification:

- Government-issued proof of identity of deceased claimant
- Proof of government identity of liquidator or heir submitting claim
- Certificate of death or copy of death certificate of deceased claimant
- The results of the will searches conducted by ***Barreau du Québec*** and ***Chambre des notaires***, and a copy of the last will and testament, if applicable

You MUST provide all the identification documents required to file a valid claim

SECTION 2 — Representative identification

This section applies only to Representatives of a minor, an incapable person or a deceased person

Representative's first name | Initial | Last name

Address

City | Province | Postal code

Home Phone - - | Business Phone - -

E-mail

Specify what proof of authorization to represent is provided:

SECTION 3 - Identification of the legal representative

This section applies only if the claim is presented by a third party (lawyer ou mandatary)

If you complete this section, all correspondence will be sent to your legal representative.

Law firm or agency name

Lawyer's or agent's first name | Initial | Last name

Adress

City | Province | Postal code

Phone -

E-mail

If you complete this section, you MUST complete Appendix « A ».

SECTION 4 — Information concerning the period(s) of preventive confinement in a Quebec hospital

Please complete the table below to the best of your knowledge for each period of preventive confinement in a Quebec hospital exceeding 72 hours. If necessary, you may add additional pages if you run out of space. Please write in capital letters.

Preventive confinement in a Quebec Hospital for more than 72 hours			
Name of Healthcare Institution			
Start date of preventive confinement			
End date of preventive confinement			
Has a court judgment been rendered regarding confinement?	Yes ☐	No ☐	Do not know ☐

Preventive confinement in a Quebec Hospital for more than 72 hours			
Name of Healthcare Institution			
Start date of preventive confinement			
End date of preventive confinement			
Has a court judgment been rendered regarding confinement?	Yes ☐	No ☐	Do not know ☐

Preventive confinement in a Quebec Hospital for more than 72 hours			
Name of Healthcare Institution			
Start date of preventive confinement			
End date of preventive confinement			
Has a court judgment been rendered regarding confinement?	Yes ☐	No ☐	Do not know ☐

For each period of protective custody, you MUST sign the following authorizations in the appendix to this form to allow the Claims Administrator access to:

- **Your health record from the health care facility where your preventive confinement took place; and**
- **If applicable, your court record in which the application for confinement was presented.**
- **To be eligible for compensation under this Settlement, you must provide these records. Without these records, your claim will be refused.**

SECTION 5 – Claimant's pecuniary claims (if applicable)

If you have incurred expenses in connection with preventive confinement that would have exceeded 72 hours, please provide details of these expenses, the amount claimed and supporting documents (in particular invoices, including proof of payment).

For example: additional parking fees with credit card statement confirming payment.

Expenses related to preventive confinement in a Quebec Hospital		
Expenses details	**Claimed amount**	**Supporting document(s) provided**
Total :	$ 0,00	

Expenses related to preventive confinement in a Quebec Hospital		
Expenses details	**Claimed amount**	**Supporting document(s) provided**
Total :	$ 0,00	

Expenses related to preventive confinement in a Quebec Hospital		
Expenses details	**Claimed amount**	**Supporting document(s) provided**
Total :	$ 0,00	

You MUST provide supporting documentation for expenses claimed.

SECTION 6 – Compensation already received

Have you ever received a monetary compensation for the preventive confinement exceeding 72 hours mentioned in your application?

☐ No (Please go to section 7)

☐ Yes

Indicate the date(s) or period(s) of preventive confinement for which you have already received compensation:

- Start date or start of period of preventative confinement: _____
- End date or end of period of preventative confinement: _____

No compensation will be paid for a preventive confinement that has already been financially compensated in the past. However, preventive confinement for which no financial compensation has been paid are eligible.

SECTION 7 - Declaration authorization of the Claimant

The undersigned:

- consents to the disclosure of the information contained herein to the extent necessary to process this claim. The undersigned acknowledges and understands that this claim form is an official Court document sanctioned by the Court overseeing the Settlement, and submitting this claim form is the same as filing it with a Court;
- authorizes the Claims Administrator and the group's Lawyers to communicate with the undersigned as necessary to administer the claim;
- confirm that I am 18 years old or older;

After reviewing the information provided in this Claim Form, the undersigned declares under penalty of perjury that the information provided in this Claim Form is true and correct to the best of his or her knowledge, information and belief.

Signature of the claimant (or his\her representative) : _____

Name in capital letters of the claimant (or his\her representative): _____

Date (dd/mm/yy) : _____

PLEASE ATTACH ALL REQUIRED SUPPORTING DOCUMENTS TO YOUR APPLICATION

Check-List:

1. Supporting documents relating to the identification of the claimant and the representative, if applicable (Sections 1 and 2).
2. If the claim is submitted by a third party (lawyer or mandatary), complete, sign and have Appendix "A" certified (any person over 18 years of age may certify).
3. Medical Records Authorization Form
4. Court File Authorization Form (if applicable)
5. Supporting documents for expenses incurred (if applicable)

Attention :

- The claim period is eight (8) months. No extension will be granted.
- Keep a copy of your claim form and all supporting documents for your records.
- If you move, send your new address to the Claims Administrator and the group's Lawyers. If you fail to notify the Claims Administrator and the group's Lawyers of a new address, your settlement benefits may not be paid to you.

Appendix « A »

CLAIMS FILED BY A LEGAL REPRESENTATIVE ON BEHALF OF THE CLAIMANT

This Appendix **only** needs to be completed **if** the application is submitted by a third party on behalf of the claimant.

I, _____ ***[name of claimant, legal representative or representative of an incapable person]*** authorize _____ [***name of legal representative (lawyer or agent)***] to file a claim form in the class action relating to preventive confinement for a period of more than 72 hours since January 1st, 2015 on my behalf and to receive any communication relevant to my claim (including the check, if eligible for payment).

DATED at _____ [***name of the city***], in the province of _____ in the country of _____ on _____ day of _____ , 202___.

Réclamant, représentant successoral OU représentant d'une personne inapte :

Signature : _____

Witness signature: _____

Name of the witness in capital letters: _____