Philips CPAP Class Action Claim Form

Instructions

Please read the instructions below carefully before filling out the claim form.

Note: We recommend that you submit your claim via the claim portal at https://cpapsettlement.kpmg.ca. Filing your claim online ensures faster processing and payment.

Types of Claims You Can Make

1. Universal Device Payment (UDP)

- **What is a UDP?** A Universal Device Payment (UDP) is a payment of up to $125 that you, or someone you are making a claim for (such as a parent, spouse, child, or a corporation), may be eligible for if you (or they) used or purchased a Recalled Product in Canada **between January 1, 2008, and June 14, 2021**.
- **Important Notes for UDP Claims:**
    - Payments are subject to deductions for court-approved legal fees.
    - Payments may be adjusted (up or down) depending on the number of people who make claims.
    - **You must provide a serial number for each Recalled Product for which you are making a claim for**. **If you do not have the serial number(s) please contact your respiratory device provider**.
    - Each Recalled Product qualifies for a separate UDP claim.
    - The list of Recalled Products can be found at: https://cpapsettlement.kpmg.ca.

2. Device Replacement Award (DRA)

- **What is a DRA?** A Device Replacement Award (DRA) is a partial reimbursement (30%-90%) for the cost of a replacement device that you, or someone you are making a claim for (such as a parent, spouse, child, or an organization) purchased between **June 14, 2021, and September 29, 2025**, because of the Recall. If you (or they) purchased a replacement device during this period, you are eligible to make a DRA claim in addition to a UDP claim.

Important Notes for DRA Claims:

- Payments are subject to deductions for court-approved legal fees.
- Payments may also be adjusted (up or down) depending on the number of people who make claims.
- You must submit receipts or other acceptable proof of purchase for the replacement device(s).
- The reimbursement amount you receive will depend on the type of machine (CPAP, BiPAP or Ventilator) and the age of the Recalled Product at the time of the Recall.
- If any portion of the replacement cost was paid for or reimbursed by an insurer, government, or another source, make sure to indicate these amounts (including taxes) in the appropriate section of the claim form.

What Happens if Your Claim is Denied?

- If your UDP or DRA claim is found to be incomplete or incorrect, the Claims Administrator will notify you. You will then have an opportunity to adjust your claim or to file another type of claim.

How to Submit Your Completed Claim Form

Once you have completed the claim form and gathered any required supporting documents, you may submit your claim by **mail or courier** to the Claims Administrator at the following address:

KPMG Inc., CPAP Settlement Claims Administrator
600 De Maisonneuve Blvd. West, Suite 1500
Montréal, Québec H3A 0A3

Please ensure that your claim form and supporting documents are complete and legible. Incomplete claims may result in delays or denied claims.

Claim Form

***Fields marked with an asterisk* (*) are mandatory in the sections applicable to your claim.**

Section 1: Claimant Information

Note: ***Even if you are making this claim on behalf of someone else, please include your own information in this section.***

Full Name*: _____

Mailing Address: * _____

Email Address[1]: _____

Phone Number: * _____

[1]If you select e-transfer as your payment method in Section 8, an email address is required.

Preferred language for Communications

☐ **English** ☐ **French**

Section 2: Claim Type

Please indicate the type of claim you are making below and proceed to the corresponding section. *

☐ I am making a claim for myself (Proceed to Section 5)

☐ I am making a claim on behalf of someone else, as their legal representative (minor, mentally incapable adult, or deceased class member (Proceed to Section 3)

☐ I am making a claim on behalf of a corporation or a related entity (Proceed to Section 4)

Section 3: Class Member Status and Relationship (if applicable)

Please check the appropriate box below to indicate the status of the Class Member on whose behalf you are submitting this claim. **The Class Member is the person for whom you are making a claim: ***

☐ Minor

☐ Mentally incapable adult

☐ Deceased class member

Name of the Class Member: * _____

Your Relationship to the Class Member (e.g., Power of Attorney, parent, guardian, estate executor): * _____

Class Member's last known address: * _____

☐ I affirm or swear that I am the legally authorized representative of the person for whom I am making this claim. *

Section 4: Corporation Details (if applicable)

Please only complete this section if you are making a claim on behalf of a corporation or related entity.

- Corporation Legal Name: * _____
- Your Position/Title at Corporation: * _____
- Your **Corporate** Email Address: * _____
- Corporation Address (if different from mailing): _____

☐ I affirm or swear that I am authorized to represent the corporation for the purposes of submitting a claim. *

☐ Supporting documentation confirming authority to make a claim on behalf of the corporation is attached (e.g., correspondence with company or entity letterhead confirming authority). *

Section 5: Recalled Product Information

Provide the following information for each **Recalled Product** you owned or used. Attach a separate page if more space is needed.

- Product Name: * _____
- Serial Number: * _____
- Purchase Date: * _____
  (YYYY-MM-DD)
  Please indicate the date of purchase of the recalled device to the best of your recollection. *
- Recalled Product Type: *

☐ CPAP ☐ BiPAP ☐ Ventilator

Section 6: Replacement Product Information (if applicable)

You are eligible for the Device Replacement Award (DRA) **only if** you purchased a replacement device for the Recalled Product(s) **that you have identified in Section 5**. Y**ou do not need to complete this section if your device was replaced for free or fully reimbursed by your insurance coverage.**

If you did **not** purchase a replacement device, you should only complete **Section 5**.

Attach a separate page if more space is needed.

- Device Brand: * _____
- Device Name or Model: * _____
- Amount Paid including tax[2]: * _____

[2]Enter the total amount you spent **including taxes and amounts covered by third-parties. Do not include accessories costs** (masks, filters, tubing, humidifiers).

- Purchase Date : * (YYYY-MM-DD) _____

If you are not certain of the purchase date, please provide an approximate date

- Do you have an invoice for the replacement device?

Receipts or invoices are the preferred form of proof of purchase and will help ensure more efficient processing of your claim.*

☐ Yes – **Please attach the invoice**

☐ No - Please attach other evidence of purchase such as photo, bank statement, email purchase confirmation.

☐ I attest that I purchased a replacement device between June 14, 2021, and September 29, 2025. *

Section 7: Third-Party Reimbursements (only for replacement devices)

Only complete this section if you purchased a replacement device and you received a third-party contribution or reimbursement to purchase the replacement device including payments and/or reimbursements made by government entities, extended health insurers, voluntary organizations, or any other third-party funder.

☐ I received third-party contributions (e.g., insurance, government, other programs) *

- Amount of third-party contribution: * _____

- Name of third-party contributor: * _____

Section 8: Payment Information

☐ e-Transfer (fastest method of payment)

☐ Cheque[3]

[3] Cheques are mandatory for claims made by corporations or on behalf of someone else.

Section 9: Attestations

☐ UDP Attestation: I attest that I, or the organization, or parent, spouse or child of mine on whose behalf I make a claim, purchased one or more Recalled Products in Canada during the class period. *

☐ DRA Attestation (if applicable): I attest that I, or the organization, or parent, spouse or child of mine on whose behalf I make a claim, purchased one or more replacement device(s) after the Recall to replace one or more of the Recalled Products attested to above. Only check this box if a replacement device was purchased and the relevant sections of this form were completed. *

Section 10: Declaration

☐ Under the penalties of perjury, I swear or affirm that all the information provided by me on this form is true, correct, and complete, and all documents I submitted are true and correct copies of what they purport to be. *

Signature: * _____

Date: * _____
(YYYY-MM-DD)

☐ I understand that the personal information collected by KPMG will be used exclusively for the purpose of processing and determining my entitlement to make a claim under the Philips CPAP Class Action Partial Settlement. The personal information provided in this claim form may also be disclosed to Class Counsel, Counsel for the Defendants, or an auditor, if applicable, for the purpose of: validating identity; carrying out any lawful investigations to confirm that I am an eligible Class Member; processing of claims; development of payment strategy; and/or reporting obligations. KPMG Canada may process applications using automation to support processing of decision-making. I understand that my personal information may be communicated to another jurisdiction within Canada and that any personal information collected, used or stored by KPMG Canada as part of this process will be in accordance with KPMG Canada's Privacy Policy. *