Thalidomide Survivors Contribution Program
Ongoing Support Payments Form

Please complete this form to tell us how you want to receive your Thalidomide Survivors Contribution Program Ongoing Payments. **Any change to your payment preferences will take effect following the Administrator's approval of this form.**

Please check one (1) box: ☐ New Enrollment ☐ Change Request	
Section 1: Thalidomide Survivor Contact Information	
First Name:	
Middle Name(s):	
Last Name:	
Date of Birth (mm/dd/yyyy):	
Sex at Birth:	☐ Male ☐ Female
Gender Identity:	☐ Male ☐ Female ☐ Other: _____
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
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 both Section 1 for the Survivor and Section 2 below for yourself.	
I have enclosed a **certified true** photocopy of one (1) of:	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:	( ) –
Relationship to Survivor	

Section 3: Please tell us how and when you want to receive your ongoing payments

You must choose between receiving your ongoing payment each year as one lump sum once per year or by installment once per month per year.

When choosing between yearly or monthly payments, please note that in the event of the death of a Survivor after the payment process begins, the Survivor's Estate will be permitted to keep the payment received in the month that the Survivor passed away if the Survivor chose to receive payments monthly. Thereafter Survivor payments would stop to the Estate. If a Survivor chose to receive a lump sum annual amount, the Estate will be permitted to keep the full amount for that year regardless of the date of death of the Survivor. Then Survivor payments would stop.

Please check (✓) the boxes below to tell us when and how you want to receive your ongoing payments:

☐ In one (1) lump sum once per year by ☐ cheque or ☐ direct deposit
or
☐ By installment once per month per year by ☐ cheque or ☐ direct deposit

Future ongoing payments will continue as indicated unless you tell us otherwise.

Section 4: Please tell us who is to receive the ongoing payments

Payments **will always be** in the name of the Thalidomide Survivor; however, may be sent to another party upon submission of legal documentation authorizing this direction of payment.

Please check (✓) **one (1)** of the boxes below to tell us who is to receive the ongoing payment on behalf of the Survivor:

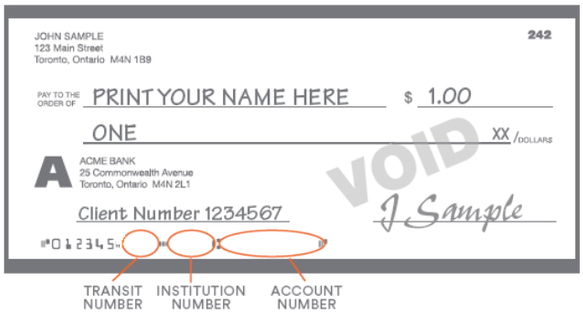
☐ Send to Survivor
or
☐ Send to Personal Representative
or
☐ Send to Other. Please complete Section 5 on the next page.

Section 5: Other (Complete this section only if ongoing payments are being sent to someone other than the Survivor or the Personal Representative)	
First Name:	
Last Name:	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –

Section 6: Payments by Direct Deposit

Complete Section 6 below only if you have chosen to receive your Ongoing Payments by direct deposit rather than by cheque. Please submit a void cheque with your form.

Bank Account Detail (Please answer all boxes)



Institution Name	
Institution Account #	Institution #
Transit #	

Completing this form authorizes the Thalidomide Survivors Contribution Program Administrator (Crawford Class Action Services) to deposit my Thalidomide Survivors Contribution Program money directly to my _____
Account as detailed above. (insert name of banking institution)

Survivor/Authorized Representative Signature:

_____

Date: Month: _____ Day: _____ Year: _____

Section 7: Declaration and Signature

Section 7 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 Thalidomide Survivors Contribution Program Ongoing Support Payments form and I understand that the Administrator will be reviewing my form for completeness and may need to contact me to request additional information. I understand that the information provided in this form is to be used to issue my annual ongoing support payments in the manner that I have indicated until I tell the Administrator otherwise.

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 ongoing support payments.

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 Sections 6 and 7 in the presence of a witness who may be a relative. The witness must complete the Witness information and sign the Witness Declaration below.

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 Thalidomide Survivors Contribution Program Ongoing Payment 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 has been included with your completed Ongoing Payments Form when returning it to the Administrator:

- ☐ For those choosing direct deposit, a photocopy of a void cheque where the deposit is to be made
- ☐ Photocopy of one (1) piece of Government Issued identification for Survivor which includes date of birth
- ☐ Photocopy of one (1) piece of Government issued identification for legally Authorized Representative which includes date of birth (if applicable)
- ☐ Certified true copy of authority to act on behalf of the Survivor (if applicable)

Please return the completed Thalidomide Survivors Contribution Program Ongoing Payments Form to the Administrator **by mail, email or fax** to:

Thalidomide Survivors Contribution Program
c/o Crawford Class Action Services
3-505 133 Weber St N
Waterloo ON N2J 3G9
tscp-pcst@crawco.ca; 1-888-842-1332

Deadline to return the completed form is by March 15, 2020 for the change to apply to the 2020-2021 FY ongoing support payment.