MONTREAL, MAINE & ATLANTIC CANADA CO.

MEDICAL DECLARATION FORM FOR POST-TRAUMATIC STRESS

INSTRUCTIONS FOR CLAIMANTS

This Medical Declaration Form ("Declaration Form") is to be completed by or on behalf of a Creditor who seeks compensation for post-traumatic stress ("PTSD Claimants") suffered as a result of the July 6, 2013 derailment ("Derailment").

The claim for post-traumatic stress can **ONLY** be brought by or on behalf of Creditors who filed a proof of claim by the claims Bar Date of **June 13, 2014 or in the case of a late claim ONLY if permitted to be filed by order of the Court. A claim for post-traumatic stress** may **NOT** be advanced on behalf of Wrongful Death Victims (as defined in the Plan).

In order to be considered for compensation, a completed Declaration Form must be received by the Monitor **NO LATER THAN Monday August 31, 2015 at 5 p.m.** as follows:

If sent by e-mail, to:	mmaclaims@richter.ca
If sent by fax, to:	1-800-246-1125
If sent by mail or courier, to:	Richter Advisory Group Inc. 1981 McGill College Ave., 12th Floor Montreal, QC H3A 0G6 Attention: MMA Claims Department

Any Declaration Form sent by fax, by messenger or by any other means of electronic mail is deemed to be received by the Monitor upon receipt. Any Declaration Form sent by mail is deemed to be received by the Monitor at the post-mark date.

Should you have any questions regarding the completion of this Declaration Form, you may contact the Monitor at **1-866-845-8958** or by e-mail at **mmaclaims@richter.ca. You may also speak with your legal counsel or a member of the Class Representatives (as defined in the Plan).**

Additional copies of the Declaration Form can be found on the Monitor's website at:
http://www.richter.ca/en/insolvency-cases/m/montreal-maine-and-atlantic-canada-co

A claim for post-traumatic stress which may be advanced fall into two broad categories which require the submission of different information.

a) **Red Zone – Short Term Claims** – this category of claim is available to Creditors who were physically present in the Red Zone at the time of the Derailment and provides compensation for short term mental health issues, **without the need to prove a clinical diagnosis/receipt of treatment**. Claims under this category require only the completion of Sections 1, 2, 3 if applicable (Representative Claimant), and 4 (Claimant Declaration).

b) **Red Zone – Long Term Claims, and non-Red Zone Short and Long Term Claims** – these categories of claim are available to Creditors who were **either i)** physically present in the Red Zone at the time of the Derailment and who seek compensation for long term mental health issues **or ii)** who were not physically present in the Red Zone at the time of the Derailment and seek compensation for either short or long term mental health issues.

All claims under category "b)" **require proof of a clinical diagnosis and/or the receipt of treatment**. Claims under category "b)" require the completion of Sections 1, 2, 3, if applicable (Representative Claimant), 4 (Claimant Declaration), and 5 (Physician/Treatment Provider Declaration).

Section 1. Claimant Identification – COMPLETE THIS SECTION FOR ALL CLAIMS

I am making a claim as a/n:

- ☐ PTSD Claimant – Red Zone - Short Term (Complete Sections 1, 2, 3, if applicable and 4)
- ☐ PTSD Claimant – Red Zone - Long Term **OR** Non-Red Zone - Short Term or Long Term (Complete Sections 1, 2, 3, if applicable, 4 and 5)
- ☐ Representative of a PTSD Claimant – (Complete Section 1, 2, 3, 4 and 5, if applicable)

Section 2. PTSD Claimant Identification – COMPLETE THIS SECTION FOR ALL CLAIMS

Last Name: _____ First Name: _____

Middle Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

E-mail: _____

Birth Date – Year: _____ Month: _____ Day: _____

Section 3. Claimant Declaration

I solemnly declare under penalty of perjury that (check ONLY one):

☐ I was physically present in the Red Zone at the time of the Derailment and this caused me short term mental health issues (between 3 months and one year);

Exact location at the time of the Derailment: _____

_____

Other people with the Claimant at the time of the Derailment (if any): _____

_____

_____

OR

☐ I was physically present in the Red Zone at the time of the Derailment and was given a clinical diagnosis of post-traumatic stress, a depressive disorder, an anxiety disorder caused by the derailment and explosion and/or otherwise received medical/clinical care for mental health issues caused by the derailment, such treatment or care lasting longer than 1 year following the derailment;

Exact location at the time of the Derailment:_____

_____

Other people with the Claimant at the time of the Derailment (if any):_____

_____

_____

OR

☐ I was not physically present in the Red Zone at the time of the Derailment but was given a clinical diagnosis of post-traumatic stress, a depressive disorder, an anxiety disorder caused by the Derailment and/or otherwise received medical/clinical care for mental health issues caused by the Derailment, such treatment or care lasting between 3 months to 1 year following the Derailment;

OR

☐ I was not physically present in the Red Zone at the time of the Derailment but have been given a clinical diagnosis of post-traumatic stress, a depressive disorder, an anxiety disorder caused by the Derailment and/or otherwise received medical/clinical care for mental health issues caused by the Derailment, such treatment or care lasting longer than 1 year following the Derailment.

Section 4. Representative Claimant Identification

This section is to be completed ONLY if you are submitting a claim as a Representative Claimant.

"Representative Claimant" means the legal representative of a PTSD Claimant, whether a minor or a person under legal disability but does NOT include Wrongful Death Claimants. You MUST provide proof of your authority to act as the representative of an PTSD Claimant.

I am applying on behalf of a PTSD Claimant who is:

- ☐ A minor (under 18 years of age)
- ☐ A person under a legal disability

I make this declaration believing it to be true

_____ _____

Signature of Claimant/Representative Claimant Date

SWORN TO before me in
this day of

Commissioner of Oaths for the
Province of Quebec

Section 5. Information and Declaration of Physician/Treatment Provider

Last Name: _____ First Name: _____

Middle Name: _____

Office Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ E-mail: _____

Medical Specialty/Professional Designation: _____

I solemnly declare under penalty of perjury that I have diagnosed the Injury Claimant identified in Section 2 of this Claim Form (check ONLY one):

☐ **with post-traumatic stress, a depressive disorder, an anxiety disorder caused by the derailment and/or otherwise received medical/clinical care for mental health issues caused by the derailment, such treatment or care lasting between 3 months to 1 year following the derailment; or**

☐ **with post-traumatic stress, a depressive disorder, an anxiety disorder caused by the derailment and/or otherwise received medical/clinical care for mental health issues caused by the derailment, such treatment or care lasting longer than 1 year following the derailment.**

_____ _____

Signature of Physician/Treatment Provider Date