Court File No. 18-00609498-00 CP

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

JOHN SOMWAR, TULSIDAI SOMWAR and SHANTA PERSAUD

Plaintiffs

-and-

FLY JAMAICA AIRWAYS LTD., THE BOEING COMPANY, ~~JOHN DOE #1 PILOT, JOHN DOE #2 CO PILOT~~ BASIL FERGUSON, KEONE BRYAN, JOHN DOE #3 AIRCRAFT MAINTENANCE PROVIDER, JOHN DOE #4 AIRCRAFT MAINTENANCE MECHANIC

Defendants

Proceedings under the Class Proceedings Act, 1992

FLY JAMAICA FLIGHT OJ256 PASSENGER PRELIMINARY QUESTIONNAIRE

Instructions

1. This questionnaire is being circulated to all passengers by Class Counsel in order to obtain information critical to the conduct of the class action lawsuit and your claim. It is important at this time to collect your personal information and preliminary data about your physical injury/injuries, emotional suffering and your financial losses, if any.

2. Please take the time that you require to fully and completely answer the questions appropriate to your circumstances. If any section or question is not applicable to you, please indicate this by writing N/A (meaning "not applicable"). Please **sign** this questionnaire. Listed below are the sections to be completed by each passenger.

Section 1 – Passenger Information
Section 2 – Fly Jamaica Flight OJ256 Information
Section 3 – Relative(s) of Passenger
Section 4 – Passenger Physical Injury/Injuries
Section 5 – Passenger Emotional Problems
Section 6 – Doctors, Clinics, Hospitals, Physiotherapists, Etc.
Section 7 – Passenger Loss of Income
Section 8 – Passenger Out of Pocket Information + Baggage Losses
Section 9 – Miscellaneous
Section 10 – Passenger Certification and Signature

3. Should you believe that you will need more space than is provided in any section of this questionnaire (e.g. out of pocket expenses or baggage losses), photocopy the section page while it is blank. Use the blank extra page to complete your response.

4. If you need assistance, please do not hesitate to call.

5. Once you have completed and signed this questionnaire, please mail the original to:

HOWIE, SACKS & HENRY LLP
Attention: Valerie Lord
20 Queen Street West, Suite 3500
Toronto, ON M5H 3R3

SECTION 1 - PASSENGER INFORMATION

Last Name:	**First:**	**Middle:**	❑ **Mr.** ❑ **Mrs.** ❑ **Ms.** ❑ **Dr.** ❑ **Miss**
Passenger Date of Birth: / / **(month) / (date) / (year)**	**Marital Status:**	**Nationality:**	**Sex:** ❑ **M** ❑ **F**
PRINCIPAL PLACE OF RESIDENCE Street Address:	**Apartment:**	**Home Phone No.:** ( )	
City:	**Province | State:**	**Postal Code:**	**Country:**
Current Occupation:	**Business Phone No.** ( )	**Mobile Phone No.** ( )	

SECTION 2 –Fly Jamaica Flight OJ256 INFORMATION				
Flight 256 Seat Assignment: **Seat #___________**	**Fight 256 Ticket Price:** $ ______________________ **Where did you purchase your ticket:** _______________________ **Manner of Purchase:** **Travel Agent** **Internet – if so, specify website used** **Other- explain**	**Round Trip Ticket:** ❑ **Yes** ❑ **No** **Bought Travel Insurance:** ❑ **Yes** ❑ **No**	**Flight 256 Ticket Paid by:** ❑ **You** ❑ **Employer** ❑ **Other** ____________	❑ **Business Trip** ❑ **Pleasure Trip**

Flight itinerary for this trip (list ALL flights):

Initially departed from: ____ **Date of departure:** _____/______/______
mm dd yyyy

List ALL connecting flights, if any below:

1. From: ____________________ **To:** ____________________ **Flight No.** _________ **Airline:** ______________________________

2. From: ____________________**To:** ____________________ **Flight No.** _________ **Airline:**______________________________

3. From: __________________ _ **To:** ____________________ **Flight No.** _________ **Airline:** ______________________________

Your final destination: ____

Did you have to fly home after the accident?	Did you pay airfare to return home?	Flight 256 baggage checked:	Flight 256 baggage lost?
❑ **Yes** ❑ **No**	❑ **Yes** **$**____________ ❑ **No** **Paid By:** ________________	❑ **Yes #**________ ❑ **No**	❑ **Yes #**______ ❑ **No**

RELATIVES of the injured passengers (meaning spouses, same-sex partners, children, grandchildren, parents, grandparents, brothers and sisters) who were not on the aircraft may be entitled to claim damages for (i) the loss of the care, guidance and companionship of the passenger caused by the accident, (ii) nursing and housekeeping services they provided to injured passengers and (iii) their out of pocket expenses as a result of the accident or the care of the injured passenger (e.g. international telephone charges, travel expenses, lost income etc.).

If any of the relatives listed above have been affected or suffered loss as a result of your injury/injuries, fill out the "Relative(s) of Passenger" section found on the next two pages.

SECTION 3 – RELATIVE(S) OF PASSENGER

RELATIVE #1

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Miss

Date of Birth: / / (mm) / (dd) / (yyyy)	Relationship to Passenger (circle one) Spouse | Partner | Child | Sibling | Grandparent | Grandchild	Living with you at time of the accident? ❑ Yes ❑ No	Sex: ❑ M ❑ F

Home Street Address:	Apartment:	Home Phone No.: ( )

City:	Province | State:	Postal Code:	Country:

Current Occupation:	Describe how relative has been affected or suffered a loss as a result of your injury/injuries: ____________________ ____________________

RELATIVE #2

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Miss

Date of Birth: / / (mm) / (dd) / (yyyy)	Relationship to Passenger (circle one) Spouse | Partner | Child | Sibling | Grandparent | Grandchild	Living with you at time of the accident? ❑ Yes ❑ No	Sex: ❑ M ❑ F

Home Street Address:	Apartment:	Home Phone No.: ( )

City:	Province | State:	Postal Code:	Country:

Current Occupation:	Describe how relative has been affected or suffered a loss as a result of your injury/injuries: ____________________ ____________________

RELATIVE #3

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Miss

Date of Birth: / / (mm) / (dd) / (yyyy)	Relationship to Passenger (circle one) Spouse | Partner | Child | Sibling | Grandparent | Grandchild	Living with you at time of the accident? ❑ Yes ❑ No	Sex: ❑ M ❑ F

Home Street Address:	Apartment:	Home Phone No.: ( )

City:	Province | State:	Postal Code:	Country:

Current Occupation:	Describe how relative has been affected or suffered a loss as a result of your injury/injuries: ____________________ ____________________

RELATIVE #4

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Miss

Date of Birth: / / (mm) / (dd) / (yyyy)	Relationship to Passenger (circle one) Spouse | Partner | Child | Sibling | Grandparent | Grandchild	Living with you at time of the accident? ❑ Yes ❑ No	Sex: ❑ M ❑ F

Home Street Address:	Apartment:	Home Phone No.: ( )

City:	Province | State:	Postal Code:	Country:

Current Occupation:	Describe how relative has been affected or suffered a loss as a result of your injury/injuries: ____________ ____________

RELATIVE #5

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Miss

Date of Birth: / / (mm) / (dd) / (yyyy)	Relationship to Passenger (circle one) Spouse | Partner | Child | Sibling | Grandparent | Grandchild	Living with you at time of the accident? ❑ Yes ❑ No	Sex: ❑ M ❑ F

Home Street Address:	Apartment:	Home Phone No.: ( )

City:	Province | State:	Postal Code:	Country:

Current Occupation:	Describe how relative has been affected or suffered a loss as a result of your injury/injuries: ____________ ____________

RELATIVE #6

Last Name:	First:	Middle:	❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. ❑ Miss

Date of Birth: / / (mm) / (dd) / (yyyy)	Relationship to Passenger (circle one) Spouse | Partner | Child | Sibling | Grandparent | Grandchild	Living with you at time of the accident? ❑ Yes ❑ No	Sex: ❑ M ❑ F

Home Street Address:	Apartment:	Home Phone No.: ( )

City:	Province | State:	Postal Code:	Country:

Current Occupation:	Describe how relative has been affected or suffered a loss as a result of your injury/injuries: ____________ ____________

SECTION 4 – PASSENGER PHYSICAL INJURY/INJURIES

Please answer the following questions for each type of injury you experienced as a result of the accident. There are three types of injuries to choose from, they are as follows:

INJURY 1	INJURY 2	INJURY 3
Broken Bones | Sprains | Related Injuries	Soreness in your Neck | Shoulders | Back | Other Parts	Any other physical injury/injuries

Please proceed to carefully read questions 1 through 13. Answer where appropriate for your circumstances.

#1 Did you suffer any PHYSICAL INJURY/INJURIES as a result of the accident? ❑ **Yes** - **If yes, detail below** ❑ **No**

Injury 1	**List Body Parts Affected:**____________________ **Describe Injury:** ____________________
Injury 2	**List Body Parts Affected:**____________________ **Describe Injury:**____________________
Injury 3	**List Body Parts Affected:**____________________ **Describe Injury:** ____________________

#2 Did you have any SURGERY for the injury/injuries? ❑ **Yes** - **If yes, detail below** ❑ **No**

	Date	Location	State Type of Surgery	Surgeon Name
Injury 1	____/____/____ M/ D / YY	City: ______________ Clinic/Hospital: ______________ ______________	______________ ______________ ______________ ______________	Dr. ______________ ______________
Injury 2	____/____/____ M/ D / YY	City: ______________ Clinic/Hospital: ______________ ______________	______________ ______________ ______________ ______________	Dr. ______________ ______________
Injury 3	____/____/____ M/ D / YY	City: ______________ Clinic/Hospital: ______________ ______________	______________ ______________ ______________ ______________	Dr. ______________ ______________

#3 Did you receive TREATMENT from a doctor, hospital, clinic or other person for the injury/injuries?

❑ **Yes - If yes, detail below** ❑ **No**

Injury 1 - Describe Treatment Received:______________________________

		Date	How Often	Location	Name of Dr. or Person who Treated You
Injury 1	Doctor Visits	Start ____/____/____ M/ D / YY End ____/____/____ M/ D / YY	________ Visits	City: ____________ Clinic/Hospital: ____________ ____________	____________ ____________
	Clinic Visits	Start ____/____/____ M/ D / YY End ____/____/____ M/ D / YY	________ Visits	City: ____________ Clinic/Hospital: ____________ ____________	____________ ____________
	Hospital Visits	Start ____/____/____ M/ D / YY End ____/____/____ M/ D / YY	________ Visits	City: ____________ Clinic/Hospital: ____________ ____________	____________ ____________
	Other Person	Start ____/____/____ M/ D / YY End ____/____/____ M/ D / YY	________ Visits	City: ____________ Clinic/Hospital: ____________ ____________	____________ ____________

Question #3 continues on the following page.

Injury 2 – Describe Treatment Received:____

		Date	How Often	Location	Name of Dr. or Person who Treated You
Injury 2	**Doctor Visits**	**Start** ____/____/____ **M/ D / YY** **End** ____/____/____ **M/ D / YY**	________ **Visits**	**City:** ____________________ **Clinic/Hospital:** ________________________ ________________________	________________________ ________________________
	Clinic Visits	**Start** ____/____/____ **M/ D / YY** **End** ____/____/____ **M/ D / YY**	________ **Visits**	**City:** ____________________ **Clinic/Hospital:** ________________________ ________________________	________________________ ________________________
	Hospital Visits	**Start** ____/____/____ **M/ D / YY** **End** ____/____/____ **M/ D / YY**	________ **Visits**	**City:** ____________________ **Clinic/Hospital:** ________________________ ________________________	________________________ ________________________
	Other Person	**Start** ____/____/____ **M/ D / YY** **End** ____/____/____ **M/ D / YY**	________ **Visits**	**City:** ____________________ **Clinic/Hospital:** ________________________ ________________________	________________________ ________________________

Question #3 continues on the following page.

Injury 3 – Describe Treatment Received: ______________________________					
		Date	**How Often**	**Location**	**Name of Dr. or Person who Treated You**
Injury 3	**Doctor Visits**	**Start** ____/____/____ **M/ D / YY** **End** ____/____/____ **M/ D / YY**	________ **Visits**	**City:** ________ **Clinic/Hospital:** ________ ________	________ ________
	Clinic Visits	**Start** ____/____/____ **M/ D / YY** **End** ____/____/____ **M/ D / YY**	________ **Visits**	**City:** ________ **Clinic/Hospital:** ________ ________	________ ________
	Hospital Visits	**Start** ____/____/____ **M/ D / YY** **End** ____/____/____ **M/ D / YY**	________ **Visits**	**City:** ________ **Clinic/Hospital:** ________ ________	________ ________
	Other Person	**Start** ____/____/____ **M/ D / YY** **End** ____/____/____ **M/ D / YY**	________ **Visits**	**City:** ________ **Clinic/Hospital:** ________ ________	________ ________

End of question #3.

Question #4 starts on the following page.

#4 Were MEDICATIONS prescribed to you for your injury/injuries? ❑ Yes - If yes, detail below ❑ No

	Name of Prescription Drug	Dosage	Took for How Long	Prescribed By
Injury 1	1.	_________mg _________ times a day		Dr.
	2.	_________mg _________ times a day		Dr.
	Name of Drug	Dosage	Took for How Long	Prescribed By
Injury 2	1.	_________mg _________ times a day		Dr.
	2.	_________mg _________ times a day		Dr.
	Name of Drug	Dosage	Took for How Long	Prescribed by
Injury 3	1.	_________mg _________ times a day		Dr.
	2.	_________mg _________ times a day		Dr.

List non-prescription medications that you have or are taking (e.g. Tylenol):

1. _______________________________ How Often: __________________________ Reason: ____
2. _______________________________ How Often: __________________________ Reason: ____
3. _______________________________ How Often: __________________________ Reason: ____

#5 Have you seen a PHYSIOTHERAPIST for your injury/injuries? ❑ Yes - If yes, detail below ❑ No

	When:	No. of Visits to Date:	How Often:	Location:	Physiotherapist's Name:	Still Going?
Injury 1			________/week			❑ Yes ❑ No
Injury 2			________/week			❑ Yes ❑ No
Injury 3			________/week			❑ Yes ❑ No

#6 Have you received any OTHER TREATMENT? ❑ **Yes** - If yes, detail below ❑ **No**

	Description of Treatment	When	Duration	How Often	From Whom?
Injury 1	1.				
	2.				
	3.				
Injury 2	1.				
	2.				
	3.				
Injury 3	1.				
	2.				
	3.				

#7 Please describe, from the time of the accident to the present, the FREQUENCY OF THE PAIN associated with the injury/injuries by the following words: constant, often, rarely. Also state how many times a day or week you feel such pain.

Injury 1	Pain Frequency: ____________________
Injury 2	Pain Frequency: ____________________
Injury 3	Pain Frequency: ____________________

#8 Please describe, from the time of the accident to the present, the INTENSITY OF THE PAIN/discomfort described above on a scale from 1 to 10 (1 = very minor, 10 = unbearable).

Injury 1	Intensity of Pain: ____________________
Injury 2	Intensity of Pain: ____________________
Injury 3	Intensity of Pain: ____________________

#9 **Are you STILL RECEVEING TREATMENT for your physical injury/injuries?** ❑ **Yes - If yes, detail below** ❑ **No**

	Treatment Description	How Often	Who is Providing Treatment?
Injury 1	1.		
	2.		
	3.		
Injury 2	1.		
	2.		
	3.		
Injury 3	1.		
	2.		
	3.		

#10 **Has your doctor/therapist told you that you will require more TREATMENT IN THE FUTURE?**

Injury 1	❑ Yes – please explain ❑ No	Future Treatment Explanation:________________________ ________________________ Name of Person Who Will Treat You:________________________
Injury 2	❑ Yes - please explain ❑ No	Future Treatment Explanation:________________________ ________________________ Name of Person Who Will Treat You:________________________
Injury 3	❑ Yes – please explain ❑ No	Future Treatment Explanation:________________________ ________________________ Name of Person Who Will Treat You: ________________________

#11 What is the PROGNOSIS of your injury/injuries?	
Injury 1	Prognosis: ____
Injury 2	Prognosis: ____
Injury 3	Prognosis: ____

#12 Following the accident, did you experience any fluctuations in your WEIGHT (increases or decreases) which are unusual for you? If yes, please describe.

____

____

____

SECTION 5 – PASSENGER EMOTIONAL PROBLEMS

Please answer the following questions using the a, b, c, d, e, scale. Circle one letter of your choice.

a	b	c	d	e
Not at all	**A little bit**	**Sometimes**	**Frequently**	**Very Frequently**

Please carefully read the questions below and answer all of them for each time period.

#1 At any time since the accident (November 9, 2018), have you had repeated, disturbing memories, thoughts or images of the airplane accident? If yes, please describe what you experience and how often during the periods listed below: ____ ____ ____ ____		Not at all	A little bit	Sometimes	Frequently	Very Frequently
1.1	During the first 2 weeks following the accident	a	b	c	d	e
1.2	Between 2 weeks and 1 month following the accident	a	b	c	d	e
1.3	Between 1 month and 2 months following the accident	a	b	c	d	e
1.4	Between 2 months following the accident until today	a	b	c	d	e

#2 At any time since the accident (November 9, 2018), have you had repeated disturbing dreams of the accident? if yes, please describe what you experienced and how often during the periods listed below: ____ ____ ____		Not at all	A little bit	Sometimes	Frequently	Very Frequently
2.1	During the first 2 weeks following the accident	a	b	c	d	e
2.2	Between 2 weeks and 1 month following the accident	a	b	c	d	e
2.3	Between 1 month and 2 months following the accident	a	b	c	d	e
2.4	Between 2 months following the accident until today	a	b	c	d	e

#3 At any time since the accident (November 9, 2018), have you suddenly acted or felt as if the accident was happening again (as if you were reliving it)? If yes, how often during the periods listed below: ______________________ ______________________		Not at all	A little bit	Sometimes	Frequently	Very Frequently
3.1	During the first 2 weeks following the accident	a	b	c	d	e
3.2	Between 2 weeks and 1 month following the accident	a	b	c	d	e
3.3	Between 1 month and 2 months following the accident	a	b	c	d	e
3.4	Between 2 months following the accident until today	a	b	c	d	e

#4 At any time since the accident (November 9, 2018), have you had the feeling of being very upset when something reminded you of the accident? If yes, how often during the periods listed below: ______________________		Not at all	A little bit	Sometimes	Frequently	Very Frequently
4.1	During the first 2 weeks following the accident	a	b	c	d	e
4.2	Between 2 weeks and 1 month following the accident	a	b	c	d	e
4.3	Between 1 month and 2 months following the accident	a	b	c	d	e
4.4	Between 2 months following the accident until today	a	b	c	d	e

#5 At any time since the accident (November 9, 2018), have you had physical reactions (e.g. heart pounding, trouble breathing, sweating) when something reminded you of the accident? If yes, what type of reactions have you experienced and how often during the periods listed below: ______________________ ______________________		Not at all	A little bit	Sometimes	Frequently	Very Frequently
5.1	During the first 2 weeks following the accident	a	b	c	d	e
5.2	Between 2 weeks and 1 month following the accident	a	b	c	d	e
5.3	Between 1 month and 2 months following the accident	a	b	c	d	e
5.4	Between 2 months following the accident until today	a	b	c	d	e

#6 At any time since the accident (November 9, 2018), have you avoided thinking or talking about the accident? If yes, how often during the periods listed below: ______________________________		Not at all	A little bit	Sometimes	Frequently	Very Frequently
6.1	During the first 2 weeks following the accident	a	b	c	d	e
6.2	Between 2 weeks and 1 month following the accident	a	b	c	d	e
6.3	Between 1 month and 2 months following the accident	a	b	c	d	e
6.4	Between 2 months following the accident until today	a	b	c	d	e

#7 At any time since the accident (November 9, 2018), have you had avoided activities or situations because they reminded you of the accident (e.g. no longer flying in an aircraft or going to the airport)? If yes, what activity or situation have you avoided and how often during the periods listed below: ______________________________ ______________________________		Not at all	A little bit	Sometimes	Frequently	Very Frequently
7.1	During the first 2 weeks following the accident	a	b	c	d	e
7.2	Between 2 weeks and 1 month following the accident	a	b	c	d	e
7.3	Between 1 month and 2 months following the accident	a	b	c	d	e
7.4	Between 2 months following the accident until today	a	b	c	d	e

#8 At any time since the accident (November 9, 2018), did you have a loss of interest in activities that you used to enjoy (e.g. movies, clubs, social or family gatherings)? If yes, which activities have you lost interest in and how often during the periods listed below: ______________________________ ______________________________		Not at all	A little bit	Sometimes	Frequently	Very Frequently
8.1	During the first 2 weeks following the accident	a	b	c	d	e
8.2	Between 2 weeks and 1 month following the accident	a	b	c	d	e
8.3	Between 1 month and 2 months following the accident	a	b	c	d	e
8.4	Between 2 months following the accident until today	a	b	c	d	e

#9 At any time since the accident (November 9, 2018), have you felt distant or cut off from other people with whom you were once close? If yes, how often during the periods listed below: ______		Not at all	A little bit	Sometimes	Frequently	Very Frequently
9.1	During the first 2 weeks following the accident	a	b	c	d	e
9.2	Between 2 weeks and 1 month following the accident	a	b	c	d	e
9.3	Between 1 month and 2 months following the accident	a	b	c	d	e
9.4	Between 2 months following the accident until today	a	b	c	d	e

#10 At any time since the accident (November 9, 2018), have you experienced difficulty falling asleep or staying asleep, irritability or outbursts of anger, difficulty concentrating, hyper vigilance or an exaggerated response to being startled? If yes, how often during the periods listed below: ______		Not at all	A little bit	Sometimes	Frequently	Very Frequently
10.1	During the first 2 weeks following the accident	a	b	c	d	e
10.2	Between 2 weeks and 1 month following the accident	a	b	c	d	e
10.3	Between 1 month and 2 months following the accident	a	b	c	d	e
10.4	Between 2 months following the accident until today	a	b	c	d	e

#11 Are you unable to remember important aspects of the accident? ❑ Yes ❑ No

#12 Have you seen any physicians, counsellors or specialists for your emotional problems since the accident? If yes, what conditions are they treating?

Name No. 1:______ Condition being treated: ______

Name No. 2:______ Condition being treated: ______

Name No. 3:______ Condition being treated: ______

#13 Have you been paying for any treatment for your emotional problems. If yes, please provide particulars of amounts paid. If not, who is paying for such treatment?

______

______

#14 **Are you able to start and complete tasks (painting, home projects)? Has this changed since the accident?**

____

____

#15 **Have there been any changes in your use of alcohol, prescription or recreational drugs since the accident?**

____

____

#16 **Are you presently taking any medication for emotional problems? If yes, did you take any such medication prior to the accident? Has the frequency or dosage of such medication changed since the accident?**

____

____

#17 **If you believe any of the above noted changes are as a result of the accident, please advise us why you think so?**

____

____

#18 **In the five (5) year period prior to the accident, (November 9, 2013), did you receive any counselling for emotional problems prior to the accident (stress, grief, depression)? If yes, please tell the type of counselling and for what type of emotional problem. Was this counselling ongoing at the time of the accident?**

____

____

____

#19 **In the five (5) year period prior to the accident, did you take any medication for emotional problems such as anti-depressants or sleeping pills? If yes, please tell us the type, frequency, duration and dosage of medication. Were you taking such medication at the time of the accident?**

____

____

____

SECTION 6 – DOCTORS CLINICS HOSPITALS PHYSIOTHERAPISTS, ETC.

List every doctor, specialist, counsellor, therapist, clinic, hospital or other person who treated you for your injury/injuries or emotional problems mentioned in this questionnaire.

No. 1

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No.2

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 3

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 4

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 5

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 6

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 7

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 8

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 9

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 10

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 11

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 12

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 13

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 14

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

No. 15

Name:	Expertise :	Business Phone No. ( )		Describe Injury Treated
Mailing Street Address:	City	Province | State	Postal Code	Country

SECTION 7 – PASSENGER LOSS OF INCOME

Please answer the following questions about your loss of income, if any. Any such loss must be as a result of the accident.

Were you working at the time of the accident? ❑ Yes ❑ No	**Where were you working at the time of the accident?**	**Are you still working there?** ❑ Yes ❑ No
What is your job title?	**How long have you worked there?** __________years _________months	**Are you self-employed?** ❑ Yes ❑ No
How may days, weeks or months of work have you missed as a result of the accident? _______days ________weeks _______months	**What is your annual gross salary?** $______________________	**What is your gross monthly salary?** $___________________
Do you have sick leave/disability benefits? ❑ Yes ❑ No	**What amount have you collected, if any from your disability plan?** $________________________	**When did you first claim disability benefits?** __________/__________/__________ (mm) (dd) (yyyy)
Have you lost income as a result of missing work? ❑ Yes ❑ No	**How much income have you lost?** $_________________________	**Name of Disability Insurer and Policy Number**
Do you expect to miss more work? ❑ Yes ❑ No	**How Much Time Do You Expect Overall to Miss?** _________weeks _________months	**How Much Income to You Expect Overall to Lose?** $______________________
Has a Medical Doctor Approved Your Absence from Work? ❑ Yes ❑ No	**Do you have a letter from your employer verifying your time off and lost wages?** ❑ Yes ❑ No	

Complete Income Tax Returns – year 2015 to present	**These documents and any other documents that you may have must be submitted to Class Counsel to confirm your time off from work, your lost wages, insurance benefits paid to you (if any), your inability to work due to "disability" arising from accident.** **You can submit these documents with this questionnaire or send them at a later date.**
T4/T4A Slips – year 2015 to present	
Medical evidence that you are/were unable to work and this "disability" is/was caused by Flight 256 accident + start and end dates of such disability	
Letter from employer/disability insurer confirming time off from work, lost wages and disability benefits paid/payable.	

SECTION 8 – PASSENGER OUT OF POCKET EXPENSES + BAGGAGE LOSSES

- **List only the <u>reasonable and necessary</u> expenses that you incurred as a result of flight 256 in this Table.**
- **Do list expenses where you have received partial reimbursement.**
- **Do not list expenses for which you have been 100% reimbursed.**
- **Receipts will be required. If you have them, please send copies of your receipts with this questionnaire**

Some <u>Examples</u>: damaged clothing or eyeglasses, uninsured medical expenses, uninsured prescription drugs, physiotherapy, massage therapy, chiropractic treatments, psychological counselling, housekeeping or home maintenance services due to disability caused by the accident, travel costs associated with seeking medical care or treatments for injuries caused by the accident.

Date mm/dd/yy	Out of Pocket Expense Description	Receipt Enclosed (circle one)	Total Cost	Currency Type	Amount Reimbursed by Health Plan or Insurance	Amount In Canadian Dollars
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$

Date mm/dd/yy	Out of Pocket Expense Description	Receipt Enclosed (circle one)	Total Cost	Currency Type	Amount Reimbursed by Health Plan or Insurance	Amount In Canadian Dollars
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
/ /		Yes / No	$		$	$
TOTAL OUT OF POCKET EXPENSES						$

Baggage Losses Log	
Please list all items contained within your lost baggage for which you have NOT been reimbursed to date. Approximate the value of each item in Canadian dollars.	
Describe Item	Value in $CDN
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$
8.	$
9.	$
10.	$
11.	$
12.	$
13.	$
14.	$
15.	$
16.	$
17.	$
18.	$
19.	$
20.	$
21.	$
22.	$
23.	$
24.	$
25.	$
26.	$
27.	$
28.	$
29.	$
30.	$
31.	$

Describe Item	Value in $CDN
32.	$
33.	$
34.	$
35.	$
36.	$
37.	$
38.	$
39.	$
40.	$
41.	$
42.	$
43.	$
44.	$
45.	$
46.	$
47.	$
48.	$
49.	$
50.	$
51.	$
52.	$
53.	$
54.	$
55.	$
56.	$
57.	$
58.	$
59.	$
60.	$
61.	$
62.	$
63.	$
64.	$
65.	$
TOTAL BAGGAGE LOSSES	$

SECTION 9 - MISCELLANEOUS

Anything else that you feel is noteworthy?

____

____

____

Do you have any questions?

____

____

____

SECTION 10 – PASSENGER CERTIFICATION & SIGNATURE

I certify that the above information provided is true and correct to the best of my knowledge.

______________________________ ______________________________

Passenger Signature *Date*

Class Counsel wish to thank you for your cooperation.