Thalidomide Survivors Contribution Program
Appeal of Assessed Disability Level Decision

Instructions

The attached Thalidomide Survivors Contribution Program ("TSCP") Appeal form is to be used to appeal the decision of the TSCP Administrator in regard to your assessed disability level.

You are allowed **one** appeal for each assessment you have completed.

The appeal is to be in writing only.

Your appeal will be reviewed by a different member of the medical assessment team. This medical professional will complete his or her own assessment of your entire file independently from the previous reviewer's assessment.

The Appeal decision will result in your disability level remaining the same or going up. It will not go down. The Appeal decision will be **final**.

Only the Thalidomide Survivor or his/her legally authorized Personal Representative may submit an appeal on behalf of the Survivor.

Please read all questions and requests for information carefully before answering. Incomplete information may lead to your appeal being delayed or denied.

Step 1 - Personal Information:

Please review and complete Section 1: Thalidomide Survivor Contact Information.

If you are a legally appointed Personal Representative submitting the appeal on behalf of the Thalidomide Survivor, you must also complete Section 2: Legally Appointed Personal Representative Information. If proof of a right to act on behalf of the Thalidomide Survivor was not previously provided or if the identity of the Personal Representative has changed, please submit proof immediately.

If someone helped you complete this form, please complete Section 3: Person who helped complete this form.

Step 2 – Details of your Appeal

Please complete Section 4 – Reason for Appeal. Please explain the reason(s) why your Appeal should be allowed. Additional pages can be used to convey important information to the assessor that you think they should know that may not have been specifically addressed in the original assessment application. If you are a Personal Representative, please list the information as it pertains to the Thalidomide Survivor.

While not required, you may choose to also include additional supporting documentation to support your Appeal such as new medical documentation not previously submitted. You are not limited to submitting medical documentation from a family practitioner solely. We suggest that you submit documentation from the medical professional(s) who best understands the nature and extent of your injuries and how those injuries have impacted your quality of life. Please be aware that you will **not** be reimbursed the cost of obtaining this additional medical information when in reference to an appeal.

Submitting photographs of your injuries, although optional, may also be helpful to the medical assessor to better understand the nature and extent of your physical injuries when information contained within medical documentation is minimal or absent.

If you choose to submit additional medical documentation that is still being obtained, it is suggested that you submit your appeal form now to meet the 45 day deadline to appeal. The medical documentation may follow thereafter.

Step 3 – Enclose Government Issued Identification and Sign the form:

Please review and complete Sections 5 and 6. If you are a Personal Representative, please sign and date the form and indicate that you are the Personal Representative.

Step 4 – Submit the form:

Please review all information in the Appeal form and make a copy for your records before you send it. Send the original form and any supporting documentation to:

Thalidomide Survivors Contribution Program
c/o Crawford Class Action Services
3-505 133 Weber St N
Waterloo ON N2J 3G9

DEADLINE TO SUBMIT YOUR APPEAL

45 days from the date of your Decision Letter advising you of your assessed disability level.

QUESTIONS? NEED HELP?
1-877-507-7706 ● 1-877-627-7027 (TTY) ● www.tscp-pcst.ca

Next Steps:

You will receive an Acknowledgement letter by mail once your Appeal form is received to let you know that we received it. If we have any questions about your Appeal form, we will contact you by telephone and/or mail so it is important to keep us informed of any changes of address or telephone numbers by calling 1-866-343-1858 or 1-877-627-7027 (TTY), or by mail at the address above, or by email to tscp-pcst@crawco.ca.

Your appeal will be assessed within 35 calendar days of receipt by the Administrator. You will receive a decision letter in regard to your appeal once your form has been reviewed by the Appeal Reviewer. The Appeal decision will be final. There will be no further right of appeal.

Thalidomide Survivors Contribution Program Appeal Form

Privacy Statement:
The information requested in this Thalidomide Survivors Contribution Program Appeal form is being collected, used and retained by the Thalidomide Survivors Contribution Program Administrator ("Administrator") and its Agents for the purpose of operating and administering the Thalidomide Survivors Contribution Program Administration pursuant to the *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5 ("PIPEDA"). The information will be provided to the Government of Canada in order to facilitate the administration of the Thalidomide Survivors Contribution Program. Personal information is protected under federal legislation, including PIPEDA and the *Privacy Act*, and personal information may be used or disclosed in accordance with applicable legislation. You have the right to request access to your personal information. To do so, call 1-877-507-7706 or 1-877-627-7027 (TTY).

Section 1: Thalidomide Survivor Contact Information	
Language Preference:	☐ English ☐ French
Communication Preference:	☐ Mail ☐ Email
Sex at Birth:	☐ Male ☐ Female
Gender Identity:	☐ Male ☐ Female ☐ Other: ____________
Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er ☐ Other (specify): ________________
First Name:	
Middle Name(s):	
Last Name:	
Date of Birth (mm/dd/yyyy):	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
Alternate Telephone Number:	( ) –
Email Address:	

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 all boxes in both Section 1 on the previous page for the Survivor and Section 2 below for yourself.

I have enclosed a **certified true** photocopy of one (1) of:	Please 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:	( ) –
Alternate Telephone Number:	( ) –
Email Address:	
Relationship to Survivor	

Section 3: Person who helped complete this form ☐ **Same as Section 2 (If this box checked, no need to complete Section 3 boxes below)**	
First Name:	
Last Name:	
Mailing Address:	
City/Town:	
Province/Territory/State/Country:	
Postal Code/Zip Code:	
Primary Telephone Number:	( ) –
Alternate Telephone Number:	( ) –
Email Address:	
Relationship to Survivor	

Section 4: Reason for Appeal

In the space below, please explain the reason(s) why you are appealing the decision of the Administrator in regard to your assessed disability level.

☐ **Additional medical documentation to follow (check box if applicable)**

Section 5: Photo Identification and Privacy

To protect your privacy and to help confirm your identity when receiving documents from you, proof of identification is required by **ALL** eligible Survivors whenever a new form is submitted. Legally appointed Personal Representatives must provide identification for **both** the Survivor and the Personal Representative.

Please submit a photocopy of one (1) of the following government issued pieces of identification for proof of identity purposes. The identification **must include your date of birth**:

- Birth Certificate
- Baptismal Certificate
- Valid Provincial Driver's License
- Valid Provincial Photo ID Card (must include date of birth)
- Canadian Passport

Section 6: Declaration and Signature

Section 6 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 Appeal form and I understand that an Appeal Reviewer, who is a medical professional, will be reviewing my appeal. I further understand that the information provided in this form and any additional supporting documentation included there with will be used to assess my appeal and that the decision of the Appeal Reviewer will be final.

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 appeal.

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 Section 6 in the presence of a witness who may be a relative. The witness must complete the Witness information below and sign the Witness Declaration on the next page.

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 Appeal 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 have been included with your Appeal form when returning it to the Administrator:

☐ Proof of identification for Survivor

☐ Proof of identification for legally Authorized Representative (if applicable)

☐ Certified true copy of their authority to act on behalf of the Survivor (if applicable)

☐ Signed and dated Declaration for Claimant/Personal Representative in Section 6

☐ Completed, signed and dated Witness section by Witness in Section 6

Please return the completed Thalidomide Survivors Contribution Program Appeal form to the Administrator **by mail postmarked** in the province or territory where the Survivor resides **within 45 calendar days of the date of the decision letter that informed you of your assessed disability level**:

Thalidomide Survivors Contribution Program
c/o Crawford Class Action Services
3-505 133 Weber St N
Waterloo ON N2J 3G9