

**MARIHUANA MEDICAL ACCESS PROGRAM  
 PRIVACY BREACH CLASS ACTION  
 OPT OUT FORM**

**OPT OUT DEADLINE  
 THURSDAY, JULY 21, 2022**

Instructions. Fill out and submit this form by mail, fax or e-mail only if you wish to be **EXCLUDED** from the Marihuana Medical Access Program Privacy Breach Class Action. Do not fill out this form if you wish to participate in the Marihuana Medical Access Program Privacy Breach Class Action.

**1. CLASS MEMBER IDENTIFICATION**

Provide the following information about the Class Member. If that person is deceased, provide the information about the person's date of death. **PLEASE PRINT**

Class Member's Last Name:	First Name:	Middle Initial:	Date of Birth: ____/____/____ YYYY      MM      DD
Home Address:	City:	Province:	Postal Code:      Date of Death (if applicable): ____/____/____ YYYY      MM      DD
Home Phone:	Work or Mobile Phone:		Email Address:
Mailing Address (only if different from address provided above):	City:	Province:	Postal Code:

**2. LAWYER, LEGAL OR ESTATE REPRESENTATIVE (IF APPLICABLE)**

If you are not the Class Member please state the source of your authority to fill out this form on behalf of the Class Member, provide the following personal identification information and attach a copy of your court order or other authorization that allows you to represent that person.

**PLEASE PRINT**

Representative Last Name:		First Name:		Relationship to Class Member	
Mailing Address:				Suite Number:	
City:	Province:	Postal Code:	Firm Name (if applicable):		
Daytime Phone:	Fax Number:		Email Address:		

I am the Estate Trustee with a will:  (attach copy of deceased's will)     
 I am the Estate Trustee without a will:  (attach copy of Certificate of Appointment)     
 I am the Power of Attorney  (attach copy of Power of Attorney)

**3. I WISH TO OPT OUT**

Check the box below to confirm your intention to opt out of the Marihuana Medical Privacy Breach Class Action.

I wish to opt out of (be excluded from) the Marihuana Medical Privacy Breach Class Action.  **I OPT OUT**

**4. SIGNATURE**

\_\_\_\_\_  
Signature of Class Member or Representative   
OR

\_\_\_\_/\_\_\_\_/\_\_\_\_  
YYYY MM DD

Submit this Opt-Out Form by 5:00 PM Eastern Time on July 21, 2022 by fax, e-mail or regular mail (regular mail must be postmarked by July 21, 2022).

Marihuana Medical Privacy Breach Class Action  
c/o Trilogy Class Action Services,  
117 Queen St., P.O. Box 1000,  
Niagara-on-the-Lake, ON, L0S 1J0,  
Fax: 416-342-1761  
Email: [optout@trilogyclassactions.ca](mailto:optout@trilogyclassactions.ca)  
Website: [www.medicalmarihuanaprivacyclassactioncanada.ca](http://www.medicalmarihuanaprivacyclassactioncanada.ca)  
Tel (Toll-Free): 1-877-406-5302