UNiD™ WARRANTY CLAIM FORM

This form is to be completed by the patient, surgeon, and/or healthcare provider, and must be received by Medicrea® should the implant covered in the Lifetime Warranty require replacement as outlined in the Warranty Terms and Conditions. The form must be completed and received at least one month before the scheduled revision surgery takes place in order for the Lifetime Warranty Terms and Conditions to be effective. For additional questions or inquiries on the Warranty and how to complete this form, please e-mail warranty@medicrea.com.

Name: _____ UNiD™ Patient ID: _____

Email: _____ Phone Number: _____

(So we may contact you to confirm case details.)

CASE DETAILS

Month (mm) **Day** (dd) **Year** (yyyy)

Initial

Surgery Date: _____ _____ _____

Surgeon Name: _____

Revision

Surgery Date: _____ _____ _____

Surgeon Name: _____

DIAGNOSTIC IMAGE REQUIREMENT

Attain the following diagnostic images from your healthcare provider and submit the images along with this Claim Form.

Requirements:

At least one Anteroposterior X-Ray and one Lateral X-Ray which include:

- o The affected (broken) implant(s)
- o Uninterrupted scan image from Cervical 2 (C2) to the Femoral Heads
- o Use of Calibration Sphere
- o Date that the diagnostic images were attained.

By signing below, you agree to the terms and conditions of the Warranty Program, provide consent to contact you at the phone number or email address above to confirm case details, and submit in best faith that the diagnostic images and information provided for the Warranty Claim are accurate.

Patient Signature: _____ Date: _____

ALMED
LISTED
NYSE
ALTERNEXT

MEDICREA® USA corp, 50 Greene Street, 4th Floor, New York, NY 10013 • USA
Phone: +1 646-490-2360 Fax: +1 866-221-4861

SURGEON VALIDATION

Please have your surgeon confirm by signing below that the structural integrity of the implanted UNiD™ Rod has been compromised (i.e. fractured).

By signing below, you, the surgeon, agree to the terms and conditions of the Warranty Program and submit in best faith that the diagnostic images and information provided for the Warranty Claim are accurate.

Surgeon Name: _____

Surgeon Hospital: _____

Surgeon Signature: _____ Date: _____

RETURN INFORMATION

Thank you for completing the Claim Form. Please mail or e-mail the completed form and required diagnostic images, as outlined in the Claim Form above, to:

mail: Medicrea Warranty Program
50 Greene Street, 4th Floor
New York, NY 10013

e-mail: warranty@medicrea.com