Benefits of the Contergan Foundation for disabled people

The Contergan Foundation Act (ContStifG) provides you the opportunity to apply for benefits from the Foundation.

Eligibility for benefits:

This is granted on the conditions that your mother received thalidomide-containing medicines by the manufacturer Grünenthal* during pregnancy and your physical defects can be attributed to this therapy. Eligibility for benefits:

Scope of benefits:

- The benefits of the Contergan pension include:
- A one-off capital sum in compensation
- A life-long monthly Contergan pension
- An annual benefits to cover specific needs
- An annual special payment
- The Contergan pension payments begin no earlier than in the month in which the claim for compensation is submitted.

Information on the application documents:

Benefits must be requested in writing. Please use the application for Contergan annuity. Complete the Background Report form completely and carefully.

Deciding on your application requires that you provide information about what medication your mother took during pregnancy.

Address for visitors:
51103 Cologne, Erna-Scheffler-Str. 3

Postal address:
50679 Cologne, Von-Gablenz-Str. 2-6

Telephone: +49 221 3673-3673
Fax: +49 221 3673-3636

E-Mail: beratung@contergan.bund.de
(General Enquiries)

E-Mail: geschaeftsstelle@contergan.bund.de
(Personal Enquiries)

DE-Mail: conterganstiftung@contergan-bund.de-mail.de

List everything you know about your impairments. Are there close relatives who might be able to provide information? Or those who remember the time of your mother's pregnancy?

- Include the following documents:
- Medical reports
- Specialist report
- X-ray images / CT / MRI / attestations
- other relevant statements, reports or letters from third parties

In brief: All documents you have on the damages you claim.

The Foundation accepts no costs that you may incur in order to obtain meaningful documentation from your doctor.

Legal basis for benefits from the Contergan foundation:

- § 12 ContStifG determines who is entitled to benefits
- § 13 ContStifG specifies the type and scope of benefits
- § 16 ContStifG describes the procedure

Contergan Foundation for Handicapped Persons
Von-Gablenz-Str. 2 - 6
50679 Cologne
Germany

Application for Contergan annuity

in accordance with § 13 of the Contergan Foundation Act

I apply for approval and payment of a

- single lump-sum compensation
- life-long monthly thalidomide annuity
- annual payment to cover specific needs
- annual special payment

Personal details:

Surname: .....

Name at birth: .....

First name: .....

Resident at

Street and house number: .....

Postal code and place: .....

Country:.....

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Date of Birth: .....

Country of birth:……..……

Place of birth: ……..……

Nationality: …….....

Contact details:

Telephone/Mobile number: .....

Email: .....

Should approval be granted, please transfer the payment to the following account:

Account holder: .....

Bank: ……

IBAN: ……..…

BIC: ……..……

....

(Place, Date) Signature of Applicant / Caregiver)

Supplement in the case of officially appointed supervision in matters concerning the administration of assets

Declaration of the person in charge of administration of assets:

I hereby submit the above application on behalf of the person in my care

……..

(Name of the person under my care)

I enclose proof of my entitlement to represent the interests of the above-mentioned person as an attachment in the original or as a certified photocopy (caregiver identity card or comparable).

Contact details of the caregiver:

Name: .....

First name: .....

Resident at/place

Street and house number: .....

Postal code and place: .....

…….....

(Signature of the Caregiver)

……., dated ……..

(Place) (Date)

Life Certificate

The employees of the Residents' Registration Office / Citizen Centre / Registry Office certify that you **appeared in person.**

Information for the employees of the registration offices:

We kindly ask the employees to support the Contergan Foundation for Disabled People by means of administrative assistance.

> §§ 4, 5 Administrative Procedure Act - VwVfG

Please fully fill out the proof of identity provided to you. Please sign it and stamp it with your official seal.

Please compare the address with a valid ID card or the like.

As an **alternative,** we also accept a certificate of residency or an extract from the register of residents if the person in question appeared in person.

> § 18 section 1 Federal Registration Act - BMG

Information for you as the party concerned:

The certificate of residency or the extract from the register of residents is given to you if you **appear in person and have a valid ID card.**

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Exceptions within Germany (list of examples)

We can accept a certificate from your attending physician if:

- you are bedridden.
- your responsible Residents' Registration Office / Citizen Centre / Registry Office does not have a handicapped accessible entrance.

Exceptions abroad (if a German embassy or German consulate cannot be reached – list of examples)

- **Brazil:** Voter registration office
- **Great Britain and Ireland:** Notaries
- **The Netherlands:** as a cross-border commuter the nearest Residents' Registration Office / Citizen Centre / Registry Office

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Proof of Identity / Life Certificate

Confirmed by the Registration Office / Citizens Registration Office / Citizens Advice Bureau (**free of charge**, as for disability benefits purposes)

We hereby confirm Mrs. / Mr.

Surname: .....

Maiden Name: .....

First Name: .....

Date of Birth: .....

Country of birth:……

Nationality: ……

registred address in : .....

.....

……

appeared **in person**.

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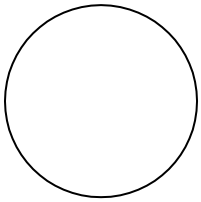
Payment of benefits from the Office of the Contergan Foundation requires the beneficiary to be living.

(§§ 12, 13 Para. 2 and 3 Contergan Foundation Act - ContStifG)



Official Seal

....

(Place, Date) (Citizens Registration Office / Citizens Advice Bureau)

Contergan Foundation for Handicapped
Persons
Von-Gablenz-Str. 2 - 6
50679 Cologne
Germany

Background report

on the suspected thalidomide injury

Personal details:

Surname: .....

First name: .....

Date of Birth: .....

Name of the product: .....

When used:.....

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Please provide information on your mother’s intake of thalidomoide-containing preparations of the Grünenthal GmbH containing thalidomide during pregnancy.

- Which medication was taken?
- When were these taken?

Proof is required. Include existing prescriptions, medical or clinic reports, or other relevant statements, reports, or letters from third parties.

....

(Place, Date) Signature of Applicant / Caregiver)

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Germany

Details of Contergan injuries

Personal details:

Surname: .....

First name: .....

Date of Birth: .....

Please give details here of the your diagnosed injuries you associate with your mother taking medication from Grünenthal GmbH containing thalidomide during pregnancy.

Please provide documentary evidence of these injuries. Enclose, for example, with the application:

- medical or clinical findings
- x-ray images
- other relevant medical documentation.

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Orthopedic injuries

Internal injuries

Ear, nose and throat injuries

Eye injuries

....

(Place, Date) Signature of Applicant / Caregiver)

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Disclaimer

in accordance with § 15 Section 2 of the Contergan Foundation Act

I have submitted an application to the Thalidomide Foundation for Handicapped Persons for a grant under § 13 of the Thalidomide Foundation Act.

Personal details:

Surname: .....

First name: .....

Date of Birth: .....

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§ 15 of the Act on the Contergan Foundation for Handicapped Persons states:

(1) Should the person entitled to benefits or their legal representatives have their place of residence or customary domicile outside the scope of this Act, they are only entitled to benefits in accordance with the provisions of this Act provided they declare in writing beforehand that they irrevocably waive any claims against Grünenthal GmbH, its shareholders, managing directors and employees that are attributed to the use of thalidomide medication.

(2) Payments already made by others who may have been responsible for the use of medication containing thalidomide are to be deducted from the payments pursuant to this Act.

1. Disclaimer

I hereby irrevocably declare that I waive my right to assert any claims against Grünenthal GmbH, its shareholders, managing directors and employees attributable to the use of medication containing thalidomide.

2. Declaration of payments made by other potentially responsible parties

I hereby make a binding declaration,

☐ to have received the following payments from other possibly responsible persons due to the use of medication containing thalidomide:

Name of the payer (paying entity):

……

Payments: ……..

☐ to have received **no** payments from other possibly responsible persons due to the use of medication containing thalidomide:

....

(Place, Date) Signature of Applicant / Caregiver)