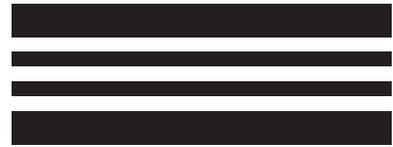


In re Thalomid and Revlimid Antitrust Litigation
Settlement Administrator
P.O. Box 43508
Providence, RI 02940-3508



THL

*In re Thalomid
and Revlimid Antitrust Litigation*
UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF
NEW JERSEY

Case No. 2:14-cv-06997

**Must be postmarked or filed electronically
on or before October 15, 2020**

CONSUMER CLAIM FORM

CLAIMANT INFORMATION

First Name				M.I.	Last Name			
Primary Address								
Primary Address Continued								
City				State	Zip Code			
Foreign Province			Foreign Postal Code		Foreign Country Name/Abbreviation			

**TO QUALIFY TO RECEIVE A PAYMENT FROM THIS SETTLEMENT,
YOU MUST COMPLETE AND SUBMIT THIS CLAIM FORM.
YOUR CLAIM MUST BE POSTMARKED OR FILED ELECTRONICALLY
ON OR BEFORE OCTOBER 15, 2020**

Mail your claim to:

In re Thalomid and Revlimid Antitrust Litigation
Settlement Administrator
P.O. Box 43508
Providence, RI 02940-3508

OR

Submit a Claim Form online at www.ThalomidRevlimidLitigation.com.



FOR CLAIMS PROCESSING ONLY	OB <input type="checkbox"/>	CB <input type="checkbox"/>	<input type="radio"/> DOC <input type="radio"/> LC <input type="radio"/> REV	<input type="radio"/> RED <input type="radio"/> A <input type="radio"/> B
----------------------------------	-----------------------------	-----------------------------	--	---

Section C: Note Regarding Documentation

You do not need to provide any documentation at this time. However, the Settlement Administrator may ask for additional proof of purchase.

Section D: Certification

I have read and am familiar with the contents of this Claim Form. I certify that the information provided by me is true, correct and complete to the best of my knowledge. I further certify that I am submitting this information on behalf of myself or a Settlement Class Member for whom I serve in the capacity of an authorized agent.

I hereby submit to the jurisdiction of the United States District Court for the District of New Jersey for all purposes connected with this Claim Form, including resolution of disputes relating to this Claim Form.

I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Claim Form was executed this _____ day of _____, 2020.

Signature: _____ Dated (mm/dd/yyyy): _____

Print Name: _____

Electronically file or mail the completed Claim Form postmarked on or before **October 15, 2020** to the following address:

In re Thalomid and Revlimid Antitrust Litigation
Settlement Administrator
P.O. Box 43508
Providence, RI 02940-3508

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form.
2. Keep a copy of your Claim Form and supporting documentation for your records.
3. If you would also like acknowledgement of receipt of your Claim Form, please complete the form online or mail this form via Certified Mail, Return Receipt Requested.

If you move and/or your name changes, please send your new address and/or your new name or contact information to the Settlement Administrator via the Settlement Website or U.S. Mail.



THIS PAGE INTENTIONALLY LEFT BLANK

