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

THIRD-PARTY PAYOR 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

ATTENTION: THIS FORM IS TO BE FILLED OUT ONLY ON BEHALF OF A THIRD-PARTY PAYOR, NOT INDIVIDUAL CONSUMERS.

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	CB	DOC / LC / REV	RED / A / B

Section A: General Information

The Settlement Administrator will use this information for all communications regarding this Claim Form. If this information changes, you MUST notify the Settlement Administrator in writing at the address above.

Company or Health Plan Name

Contact Name

Address 1

Address 2 | Floor/Suite

City | State | ZIP Code

Email Address

— —

Area Code - Telephone Number | Tax Identification Number

List all other names by which your company or health plan has been known and any other Federal Employer Identification Numbers ("FEINs") you have used before May 20, 2020 (use a separate sheet if necessary).

Company or Health Plan Name

Federal Employer Identification Number

○ Health Insurance Company/HMO ○ Self-Insured Employee Health Plan ○ Self-Insured Health & Welfare Fund

○ Other (Explain)

Section B: Authorized Agent Only

The Settlement Administrator will use this information for all communications regarding this Claim Form. If this information changes, you MUST notify the Settlement Administrator in writing at the address above.

* As an Authorized Agent, please indicate how your relationship with the Settlement Class Member(s) is best described:

- ○ Third-Party Administrator
- ○ Pharmacy Benefits Manager
- ○ Other (Explain)

Authorized Agent's Company Name

Contact Name

Address | Floor/Suite

City | State | ZIP Code

Email Address

Area Code - Telephone Number | Authorized Agent's Tax Identification Number

Please list the name, address and FEIN of every Settlement Class Member (*i.e.,* Company or Health Plan) for whom you have been duly authorized to submit this Claim Form (attach additional sheets to this Claim Form as necessary). Alternatively, you may submit the requested list of Settlement Class Member names, addresses, and FEINs in an electronic format, such as Excel or a tab-delimited text file. Please contact the Settlement Administrator to determine what formats are acceptable.

Settlement Class Member's Name

Address (if avaliable)

City | State | ZIP Code

Settlement Class Member's FEIN

Settlement Class Member's Name

Address (if avaliable)

City State ZIP Code

Settlement Class Member's FEIN

Settlement Class Member's Name

Address (if avaliable)

City State ZIP Code

Settlement Class Member's FEIN

Settlement Class Member's Name

Address (if avaliable)

City State ZIP Code

Settlement Class Member's FEIN

Settlement Class Member's Name

Address (if avaliable)

City State ZIP Code

Settlement Class Member's FEIN

Section C: Purchase Information

Provide the amount of money you spent on each drug for prescriptions filled before May 20, 2020 for use by your members, employees, insureds, participants, or beneficiaries in California, the District of Columbia, Florida, Kansas, Maine, Massachusetts, Michigan, Nebraska, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, or Tennessee. Include purchases made on behalf of members, employees, insureds, participants, or beneficiaries located in one of these states or those that requested to have the prescription filled while located in one of these states, purchases processed in a billing department located in one of these states, or payments made to pharmacies located in one of these states.

Settlement Class Member's Name

$. Total amount spent on Thalomid

$. Total amount spent on Revlimid

Settlement Class Member's Name

$. Total amount spent on Thalomid

$. Total amount spent on Revlimid

Settlement Class Member's Name

$. Total amount spent on Thalomid

$. Total amount spent on Revlimid

Settlement Class Member's Name

$. Total amount spent on Thalomid

$. Total amount spent on Revlimid

Settlement Class Member's Name

$. Total amount spent on Thalomid

$. Total amount spent on Revlimid

Settlement Class Member's Name

$. Total amount spent on Thalomid

$. Total amount spent on Revlimid

Section D: Documentation

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

Section E: 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.
4. 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.