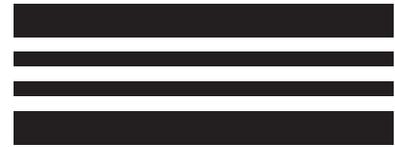


In re Thalomid and Revlimid Antitrust Litigation
Settlement Administrator
P.O. Box 43508
Providence, RI 02940-3508



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 <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
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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		
<input type="radio"/> Health Insurance Company/HMO	<input type="radio"/> Self-Insured Employee Health Plan	<input type="radio"/> Self-Insured Health & Welfare Fund
<input type="radio"/> 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 available)

City

State

ZIP Code

Settlement Class Member's FEIN



Settlement Class Member's Name

Address (if available)

City

State

ZIP Code

Settlement Class Member's FEIN

Settlement Class Member's Name

Address (if available)

City

State

ZIP Code

Settlement Class Member's FEIN

Settlement Class Member's Name

Address (if available)

City

State

ZIP Code

Settlement Class Member's FEIN

Settlement Class Member's Name

Address (if available)

City

State

ZIP Code

Settlement Class Member's FEIN



Section D: Documentation

You do not need to provide any documentation at this time. 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.

