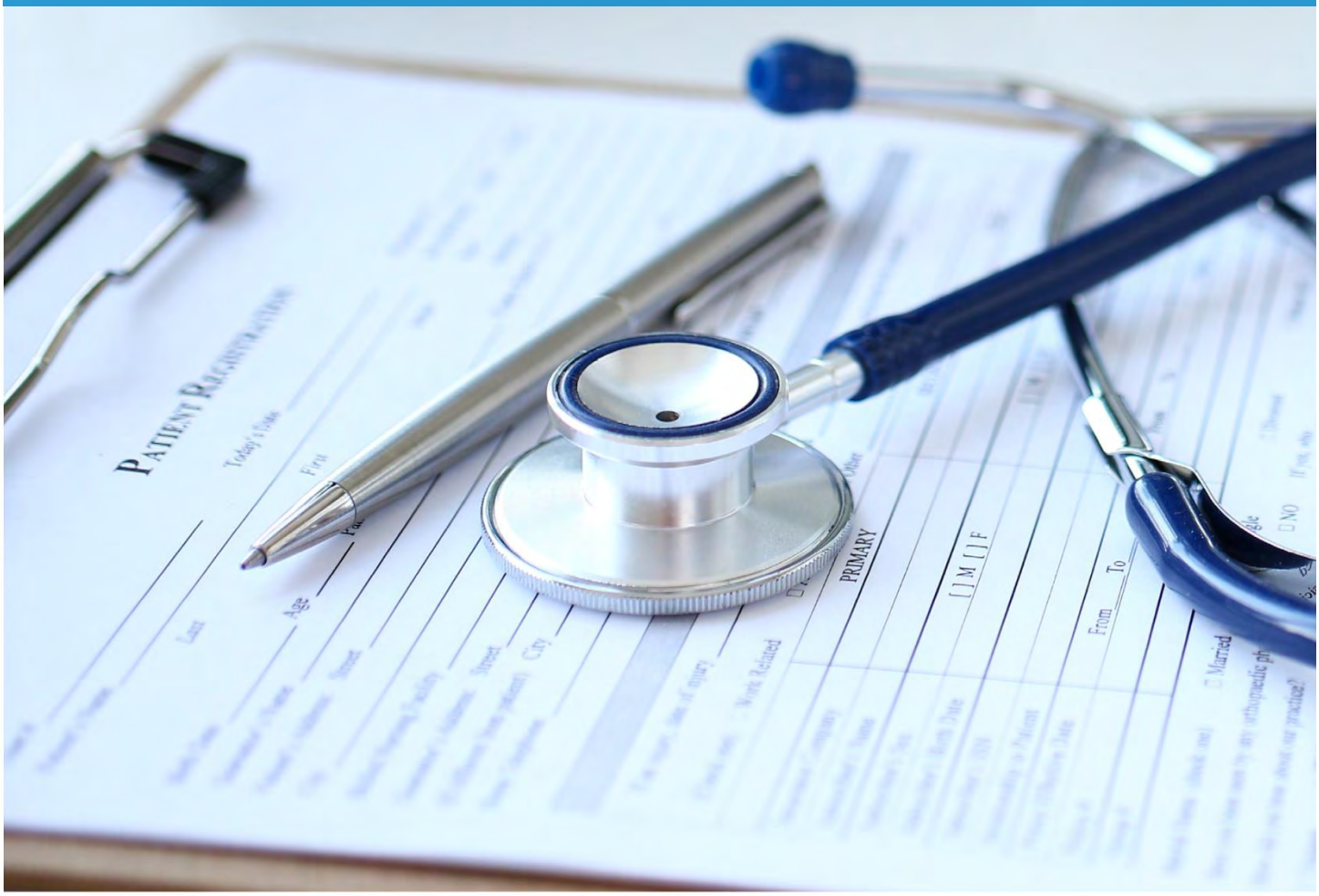
Blue Cross Blue Shield Settlement

CLAIM FORM



Must be postmarked by mail no later than November 5, 2021

BLUE CROSS BLUE SHIELD SETTLEMENT
C/O JND LEGAL ADMINISTRATION
PO BOX 91390
SEATTLE, WA 98111
www.BCBSsettlement.com

BLUE CROSS BLUE SHIELD CLAIM FORM

You may be eligible to receive a cash payment if you are an **Individual**, **Insured Group** (and their employees) or **Self-Funded Account** (and their employees) that **purchased** or **were enrolled** in a Blue Cross or Blue Shield (BCBS) health insurance or administrative services plan during one of the two Settlement Class Periods.

The Settlement Class Period for **Individuals** and **Insured Groups** (and their employees) is from February 7, 2008, through October 16, 2020. The Settlement Class Period for **Self-Funded Accounts** (and their employees) is from September 1, 2015 through October 16, 2020. Dependents, beneficiaries (including minors), and non-employees are **NOT** eligible to receive payment.

The Easiest Way to File is Online at www.BCBSsettlement.com.

INSTRUCTIONS FOR COMPLETING THIS CLAIM FORM

1. **Please provide below, and on page 8, the Unique ID contained in the email or on the postcard notice that you received.** If you did not receive an email or postcard, or if you cannot locate your email/postcard, write "unavailable."

UNIQUE ID:	

2.  If you are a company/business/entity that purchased a BCBS health insurance or administrative services plan from a BCBS company, please complete **Section A**.

3.  If you are an individual who purchased BCBS health insurance directly from a BCBS company (and NOT an employee enrolled through a company/business/entity), please complete **Section B**.

4.  If you are an individual who was enrolled in a BCBS health insurance or administrative services plan through your employer or an individual that otherwise purchased a BCBS health insurance or administrative services plan through another group entity such as a union or member association (but NOT directly from a BCBS company), please complete **Section C**.

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INSTRUCTIONS CONTINUED

5. If you are an individual who purchased BCBS health insurance directly from a BCBS company AND also were enrolled in a BCBS health insurance or administrative services plan through your employer or other entity, you must complete **Sections B and C** of this claim form.

6. Review **Section D** if you filled out **Section A or Section C**. Otherwise you may skip to **Section E**.

7. All claimants must complete **Section E**, regarding payment election.

8. You must sign the claim form certification in **Section F** and mail it to the address below, postmarked by **November 5, 2021**, in order for your claim to be considered. Or you can quickly complete this claim form online at www.BCBSsettlement.com.

Blue Cross Blue Shield Settlement
C/O JND Legal Administration
PO Box 91390
Seattle, WA 98111

9. **ONLY** complete the chart on page 9 if you had more than one health plan or administrative services plan or if you were enrolled in BCBS health insurance or administrative services plans through more than one employer.

10. Please consult the checklist on page 10 before submitting your claim.

By submission of this claim form, you are consenting to the disclosure of your information for use by the Claims Administrator and the Settlement Administrator in the claims administration process. The information you provide us on this claim is confidential and will be used solely to contact you and to process your claim. It will not be used for any other purpose.

Failure to submit your claim form by November 5, 2021 will subject your claim to rejection and will preclude you from being eligible to receive any money in connection with the Settlement. Do not mail or deliver your claim form to the Court.

SECTION A: BUSINESSES

To be Completed Only on Behalf of Companies/Businesses/Entities That Purchased BCBS Health Insurance or Administrative Services Plans from a BCBS Company.

1. FULL NAME OF COMPANY:				
2. PRIMARY HEADQUARTERS MAILING ADDRESS:	Street Address Line 1			
	Street Address Line 2			
	City		State	Zip
3. COMPANY CONTACT (NAME AND TITLE):	First	M.I.	Last	
	Title			
4. OFFICE PHONE NUMBER:				Ext.
5. EMAIL ADDRESS:				
6. NAME OF CONTRACTED BLUE CROSS OR BLUE SHIELD BRANDED HEALTH PLAN[1]:				
7. BLUE CROSS OR BLUE SHIELD GROUP #:				
8. COVERAGE START AND END DATES: (MM/YYYY)	Start Date		End Date	
9. FOR PLANS PURCHASED THROUGH A PURCHASING ENTITY	☐ Check this box if your company/business/entity acquired its health plan through another purchasing entity, such as a PEO. Please state the name of the purchasing entity: _____ ☐ Check this box if you are a Professional Employer Organization ("PEO"), Union or Trade Association, or other associational entity that collected payment for, contracted with or purchased a BCBS health insurance or administrative services plan on behalf of your client companies, customers or members directly from a BCBS company.			

[1] If you had multiple health insurance or administrative services plans, complete the chart on page 9 instead of fields 6 through 8.

SECTION B: INDIVIDUAL MEMBERS

To be Completed Only by Individuals Who Purchased Health Insurance Directly from a BCBS Company.

1. SUBSCRIBER FULL NAME:	First	M.I.	Last	
2. MAILING ADDRESS:	Street Address Line 1			
	Street Address Line 2			
	City	State	Zip	
3. PHONE NUMBER:				
4. EMAIL ADDRESS:				
5. NAME OF BLUE CROSS OR BLUE SHIELD BRANDED HEALTH PLAN[2]:				
6. BLUE CROSS OR BLUE SHIELD GROUP #:				
7. SUBSCRIBER ID:				
8. COVERAGE START AND END DATES: (MM/YYYY)	Start Date	End Date		

[2] If you had multiple health insurance plans, complete the chart on page 9 instead of fields 5 through 8.

SECTION C: EMPLOYEES

To be Completed Only by Individuals Who Were Enrolled in BCBS Health Insurance or Administrative Services Plans Through Their Employers or Who Otherwise Purchased BCBS Health Insurance or Administrative Services Plans Through Other Group Entities.

1. SUBSCRIBER FULL NAME:	First	M.I.	Last	
2. MAILING ADDRESS:	Street Address Line 1			
	Street Address Line 2			
	City	State	Zip	
3. PHONE NUMBER:				
4. EMAIL ADDRESS:				
5. NAME OF EMPLOYER OR GROUP ENTITY THROUGH WHICH YOU WERE PROVIDED BLUE CROSS OR BLUE SHIELD INSURANCE[3]:				
6. MAILING ADDRESS OF EMPLOYER OR GROUP ENTITY:				
7. NAME OF BLUE CROSS OR BLUE SHIELD BRANDED HEALTH PLAN[4]:				
8. BLUE CROSS OR BLUE SHIELD GROUP #:				
9. SUBSCRIBER ID:				
10. COVERAGE START AND END DATES: (MM/YYYY)	Start Date	End Date		

[3] If you purchased BCBS health insurance or administrative services plans through more than one employer, complete the chart on page 9 instead of fields 5 and 6.
[4] If you had multiple health insurance or administrative services plans, complete the chart on page 9 instead of fields 7 through 10.

SECTION D: EXPLANATION OF EMPLOYER/EMPLOYEE PREMIUM PERCENTAGES

This Section Only Applies to claimants who filled out **Section A** OR **Section C**.

The Settlement provides that payments will be based, in part, on premiums paid for BCBS health insurance or administrative services plans during the relevant periods between 2008 and 2020.

The Settlement further provides default formulas for the Claims Administrator to use when determining what percentage of the premium was paid by an employer/entity and what percentage was contributed by its employees/members.

> *100% of premiums for employees who do not file claims are allocated to the claiming employer. When an employee does claim, their premium share is determined through the default formulas, which provide that employees with single coverage are allocated 15% (for fully-insured health insurance) or 18% (for administrative plans) of the total premium paid on their behalf by their employer, and employees with family coverage are allocated 34% (for fully-insured health insurance) or 25% (for administrative plans), with the remainder allocated to the employer. For a full discussion of how these formulas will be used in calculating claims, please refer to the Plan of Distribution on the Settlement Website.*

DEFAULT OPTION

- **If you accept the Default Option**, you are **NOT** required to provide any additional data or evidence in support of your claim at this time.
- If another claimant's filing affects your claim, you will be provided with an opportunity to respond at a later date.

ALTERNATIVE OPTION

- **If you would like to apply for an alternative contribution percentage** instead of using the assigned Default Option, you must complete the table on page 7.
- If you select this option, you must also provide data or evidence to support the percentages you list in the table.
- For any time period for which supporting data or evidence is not provided, the above Default Option will be applied.
- Selection of the Alternative Option does not ensure a contribution percentage higher than or equal to the Default Option. Your percentage will be dependent on a review process that includes a review of all materials submitted pertaining to your premium.

SECTION D CONTINUED

STOP: If you want to use the DEFAULT OPTION, DO NOT FILL OUT THIS SECTION.

If you would like to use the **ALTERNATIVE OPTION** instead of receiving the Default Option, please state the percentage contribution you believe you contributed for each year that you were enrolled in a BCBS health insurance or administrative services plan.

Year	Percentage (%)
2008	
2009	
2010	
2011	
2012	
2013	
2014	
2015	
2016	
2017	
2018	
2019	
2020	

REMINDER: If you choose to apply for an alternative contribution percentage you must supply documentation with this claim form supporting the percentage you claim to have contributed. If you fill out this chart to apply for an alternative contribution percentage without providing additional documentation, the above Default Option will be applied to your claim.

SECTION E: PAYMENT ELECTION

Please let us know how you would like to receive your settlement payment if your claim is deemed valid. **You may only check one box below**.

Final determinations of claim amounts will not be made until after processing by the Claims Administrator is complete. Claims will not be paid if the value is equal to or less than $5.00.

Claimants who submit valid, approved claims shall receive a pro-rata percentage of the Net Settlement Fund allocated to their type of coverage (fully-insured or self-funded) based upon their estimated proportion of the cumulative total of premiums and/or administrative fees paid by all claimants.

I would like to receive my payment…

☐ **By Venmo** ➔ Username: _____

☐ **By PayPal** ➔ Email: _____

☐ By Pre-paid Card

☐ By Check

YOU MUST SIGN AND DATE YOUR CLAIM FORM BELOW IN ORDER TO BE ELIGIBLE TO BE PAID IN THIS SETTLEMENT

SECTION F: SIGNATURE

I affirm under the laws of the United States and the laws of my State of residence that the information supplied in this Claim Form by the undersigned is true and correct to the best of my recollection, and that this form was executed on the date set forth below.

I understand that I may be asked to provide supplemental information to the Claims Administrator and/or Settlement Administrator before my claim will be considered complete and valid.

UNIQUE ID:	

Signature:	**Dated:**
Print Name:	**Title** (if signing on behalf of company/business/entity)**:**

INFORMATION FOR ADDITIONAL HEALTH PLANS/EMPLOYERS

To be Completed Only if You Participated in Multiple BCBS Health Insurance or Administrative Services Plans or if You Were Enrolled in BCBS Health Insurance or Administrative Services Plans Through Multiple Employers/Entities.

If you require more space than the chart below provides, ***you should file online at www.BCBSsettlement.com****.*
Or, you may make multiple copies of this page.

Name of Blue Cross or Blue Shield Branded Health Plan	Blue Cross or Blue Shield Group #	Subscriber ID (For Individuals Only)	Name of employer or group entity through which you were provided insurance	Mailing address of employer or group entity	Coverage Start Date (MM/YYYY)	Coverage End Date (MM/YYYY)

CHECKLIST

- ✓ Did you include your Unique ID on page 1 and page 8? Or, if you do not have a Unique ID, did you write "unavailable"?
- ✓ Did you complete all fields in Section A, B or C, as applicable?
- ✓ If you elected the Alternative Option in Section D, did you include supporting documentation or information?
- ✓ Did you complete Section E and tell us how you want to receive payment?
- ✓ Did you sign and date the claim form at Section F?
- ✓ Did you mail your form prior to the deadline?

If any of your contact information changes, you must promptly notify us by emailing info@BCBSsettlement.com.

Please note that Settlement benefits will be distributed after the Settlement is approved by the Court and final. Please be patient.