PATIENT CLAIM FORM

RICHARDS V. UNITED HOSPITAL CENTER INC CLASS ACTION SETTLEMENT

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SECTION A – OVERVIEW

This Settlement applies to Patients or their Authorized Agent or Representative, who requested and paid for medical records from United Hospital Center, Inc. from September 10, 2008 through June 5, 2014 (the "Class"). Settlement FAQs, a more detailed description of the Class and the Class Members, and a description of how the refund will be computed is contained on the Settlement website, UHCMedicalRecordsOvercharge.com.

According to our records, you are a Patient who was seen at United Hospital Center, Inc., from September 10, 2006 through June 5, 2014. As a result, you may have requested and paid for medical records from United Hospital Center, Inc. from September 10, 2008 through June 5, 2014 (the "Class Period").

If you did request and pay for medical records from United Hospital Center, Inc. during the Class Period, you may be entitled to a payment.

If you have any questions, please review the FAQs on the website or call or email us.

YOU MUST MAIL, EMAIL, OR SUBMIT ONLINE YOUR COMPLETED CLAIM FORM BY MAY 3, 2027, TO HAVE YOUR CLAIM REVIEWED.

SECTION B – PATIENT INFORMATION

_____ _____
Patient Name Unique Identifier # found on Notice Postcard

_____
Mailing Address

_____ _____ _____
City State Zip

Patient Physical Address (if different from Mailing Address)

_____
Physical Address

_____ _____ _____
City State Zip

_____ _____
Telephone Number E-mail Address

_____ _____
Last 4 of Patient Social Security Number Date of Birth

SECTION C – EXCESS COPY CHARGE (CHOOSE AN OPTION)

_____OPTION 1 – I was a Patient or an Agent of a Patient that requested in writing and paid for medical records from United Hospital Center, Inc. from September 10, 2008 through June 5, 2014. I understand that without actual proof of payment, and if my claim is confirmed, I shall be paid a flat $100.00 award, unless there is insufficient money available in the fund after paying all amounts owing for Claimants with actual proof of payment, in which case I will be paid pro rata.

_____OPTION 2 – I was a Patient or an Agent of a Patient that requested in writing and paid for medical records from United Hospital Center, Inc. from September 10, 2008 through June 5, 2014, and I will be providing actual proof of payment. I understand that Claims with actual proof of payment, if confirmed, shall be paid at full value minus $2.08, unless those claims exceed the total amount payable ($600,000.00), then they shall be paid pro rata. I have attached to this Claim Form documentation showing actual proof of payment.

SECTION D – IDENTIFICATION INFORMATION OWNING A PAYMENT

Please complete Section B, confirming your information and providing the last 4 digits of the Patients SSN(required to confirm Patient eligibility), and the Patient Date of Birth, address, and unique identifier found on your Notice Postcard, complete Section C, selecting a Clam Option and sign and return this Claim Form by mail or email to the address above, or by submitting your Claim Form using the Settlement website UHCMedicalRecordsOvercharge.com, by **MAY 3, 2027**.

SECTION E - CERTIFICATION

I certify, under penalty of perjury, that, I have read and understand the information set forth in this Claim Form and it is true and correct to the best of my knowledge.

_____ _____

Patient Signature Date

(or signature of Agent/Requester Representative if Patient is Incapacitated, Minor or Deceased)

_____

Print Name