CLAIM FORM FOR THE BLUE CROSS AND BLUE SHIELD PARTIES' SETTLEMENT FUND AND ELECTION OF CONTRIBUTION TO CHARITABLE FOUNDATION OR ORGANIZATION

You must read the Notice of Proposed Settlement and Claim Form Instructions before completing this Claim Form. The capitalized terms used in this Claim Form are defined in the Settlement Agreement. A Class Member may file only one Claim Form.

SECTION A: CLAIMANT INFORMATION - ALL CLAIMANTS MUST COMPLETE THIS SECTION (BY EITHER A PHYSICIAN GROUP/ORGANIZATION OR AN INDIVIDUAL PHYSICIAN, BUT NOT BOTH).

Check One:

☐ **Physician Group/Organization** Please indicate the number of Physicians on your list _____

Physician Group or Organization Name	
Name and Title of Employee/Representative Filing	*Phone*

Physician Groups/Organizations must attach a list of Active Physicians for whom they are submitting claims, along with the information specified in the Claim Form Instructions enclosed with this mailing for each Active Physician for whom the Physician Group/Organization is submitting a Claim. This information should be set forth on the rider that is attached to this Claim Form, or, alternatively, on a form substantially similar to the one that is attached.

☐ **Individual Physician** Please indicate your Physician type (e.g., MD or DO) _____

Name of Physician	
*Name of Representative (if Physician is Deceased)**	*Phone*

*If you are the legal heir or representative of a deceased Class Member, you must attach documentation such as a death certificate or letters of administration for an estate to confirm your status. The Tax I.D. requested in Section E is that of the heir or estate.

Mailing Address for Physician Group/Organization or Individual Claimant

Mailing Address (Street, PO Box, Suite or Office Number, as applicable)			
City	*State*	*Zip Code*	*Blue Cross/Blue Shield Provider Number (if applicable)*

Individual Claimants, please check the appropriate box in SECTION B or SECTION C to indicate the category of which you are a member.

SECTION B: I AM A CLASS MEMBER WHO HAS RETIRED FROM THE PRACTICE OF MEDICINE OR HAS BECOME INACTIVE SUBSEQUENT TO MAY 22, 1999 OR I AM THE LEGAL HEIR OR REPRESENTATIVE OF A DECEASED CLASS MEMBER.

☐ By checking the box to the left, I certify that I have reviewed the enclosed Notice of Proposed Settlement and Claim Form Instructions and that I am either a Class Member (as described in the enclosed Notice of Proposed Settlement and defined in the Settlement Agreement) who has retired from the practice of medicine or become inactive subsequent to May 22, 1999 (a "Retired Physician") or that I am the legal heir or representative of a deceased Class Member.

SECTION C: I AM A CLASS MEMBER AND AN ACTIVE PHYSICIAN.

☐ By checking the box to the left, I certify that I have reviewed the enclosed Notice of Proposed Settlement and Claim Form Instructions and that I am a Class Member (as described in the enclosed Notice of Proposed Settlement and defined in the Settlement Agreement) and that I am an Active Physician.

ACTIVE PHYSICIANS: Individual Physicians must check **ONLY ONE** of the boxes below to designate the range of Gross Receipts that are the basis of this claim. **Physician Groups and Physician Organizations** must attach a list that designates the range of Gross Receipts for **each Active Physician** for whom you are filing this claim (by using the attached rider or, alternatively a form that is substantially similar to the one that is attached). **Physician Groups and Physician Organizations do not check any boxes below.**

By checking ONE of the boxes below, I certify that my Gross Receipts for providing Covered Services to the settling Blue Plans' Plan Members during the three calendar year period of 2004, 2005, and 2006 were at the dollar level indicated:

I. ☐ Less than $ 5,000, or that I am a member of the Settlement Class in John R. Gregg, M.D., et al. v. Independence Blue Cross, et al.; Robert P. Good, M.D. v. Independence Blue Cross, et al.; and Pennsylvania Orthopaedic Society v. Independence Blue Cross, et al. ("IBC Class Action Settlement"), who did not opt out of the IBC Class Action Settlement and I am relying solely on Gross Receipts for providing Covered Services to IBC Members to recover from the Settlement Fund.

II. ☐ At least $ 5,000 but less than $ 50,000.

III. ☐ $ 50,000 or greater.

IV. ☐ I am submitting receipts for another consecutive three - year period between January 1, 1997 and December 31, 2006

If you only received payments from a Blue Cross and/or Blue Shield plan that is NOT listed in the notice, please check Box 1 above.

If you checked Boxes I, II or III in Section C, please move to Section D.

If you checked Box IV in Section C, please indicate in the table below the dates of the consecutive three - year period that are the basis of your claim and check the appropriate box to indicate for this three-year period the range of Gross Receipts you received for providing Covered Services to the settling Blue Plans' Plan Members. You must attach your proof or receipts and print a description of the proof you attached in the box below.

	☐ under $5,000	☐ $ 5,000 - $49,999	☐ $ 50,000 or over
Dates of the Three-Year Period	*Description of the Proof Attached.*		

SECTION D: INSTRUCTIONS FOR PAYMENT - ALL CLAIMANTS MUST COMPLETE THIS SECTION.

☐ By checking this box, I am directing the Settlement Administrator to remit payment of the *pro rata* portion of the Settlement Fund for an eligible claim directly to me (i.e., to the Class Member completing this claim, which may be an individual Physician or Physician Group or Physician Organization).

☐ By checking this box, I am directing the Settlement Administrator to donate the *pro rata* portion of the Settlement Fund for an eligible claim to the eligible organization that I have selected from the list on page 4 of the Claim Form Instructions (select only one eligible organization).

CLEARLY print the number preceding the eligible organization you are selecting from the list on page 4 of the Claim Form Instructions in the box to the right.

Charitable Organization Number

SECTION E: SUBSTITUTE W-9 - ALL CLAIMANTS MUST COMPLETE THIS SECTION.

On the appropriate line, enter the Social Security Number or Employer Identification Number of the claimant whose name will appear on any check and related Form-1099. For individuals, this is your Social Security Number (SSN). For Physician Groups and Physician Organizations, this is your Employer Identification Number (EIN).

_____-_____-_____ OR _____-_____

Social Security Number (SSN) Employer Identification Number (EIN)

By signing this Claim Form, I certify that:

1. The number shown on this form above is the correct Social Security Number or Employer Identification Number for this claimant;

2. The claimant is not subject to backup withholding because the claimant: (a) is exempt from backup withholding, or (b) has not been notified by the Internal Revenue Service (IRS) that the claimant is subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified the claimant that the claimant is no longer subject to backup withholding; and

3. The claimant is a US Citizen.

NOTE: Backup withholding is extra tax withholding that occurs when a taxpayer has underreported interest or dividends in a previous year. The IRS notifies taxpayers who are subject to backup withholding. If you (the claimant) have been notified by the IRS that you are subject to backup withholding because you have failed to report all interest and dividends on your tax return, you must cross out item 2 above by placing a line through the section.

SECTION F: CERTIFICATION - ALL CLAIMANTS MUST COMPLETE THIS SECTION.

I do declare and certify, under penalties of perjury, as follows:

- I am a Class Member, a legal heir or representative of a deceased Class Member, or an authorized representative of the Physician Group or Organization identified above;
- I am not submitting a claim on behalf of any Class Members that have submitted a request to Opt-Out of the Class and Settlement;
- I am not submitting a claim on behalf of any Active Physicians who are, on their own behalf, submitting separate claims based on the same Covered Services;
- **I am not submitting a claim on behalf of any Active Physicians against whom a Blue Plan has obtained a finding of fraud and/or abuse from a judicial, arbitral, or administrative proceeding and a corresponding judgment for damages during the same time period for which the claim is asserted;** and
- All of the statements and information provided in this Claim Form are true, correct and complete.
- **The IRS does not require your consent to any provision of this document other than the certifications in Section E required to avoid backup withholding.**

_____ _____

Signature Date

Claims should be sent to the Settlement Administrator at:

Blue Parties'
Settlement Administrator
PO Box 4349
Portland, OR 97208-4349

YOU MUST COMPLETE AND SIGN THIS CLAIM FORM, AND THE ENVELOPE RETURNING YOUR CLAIM FORM MUST BE MAILED TO THE SETTLEMENT ADMINISTRATOR WITH A POSTMARK DATE NO LATER THAN OCTOBER 19, 2007.

IF YOUR SIGNED CLAIM FORM IS NOT MAILED TO THE SETTLEMENT ADMINISTRATOR BY THIS DEADLINE, YOU WILL BE DEEMED TO HAVE WAIVED YOUR RIGHT TO RECEIVE ANY PAYMENT FROM THE SETTLEMENT FUND.

WE STRONGLY RECOMMEND SENDING YOUR CLAIM FORM VIA REGISTERED OR CERTIFIED MAIL AND RETAINING YOUR RECEIPT AND A COPY OF YOUR CLAIM FORM FOR YOUR RECORDS.

If you have any questions, please call the Settlement Administrator at (877) 893-2643.

RIDER FOR PHYSICIAN GROUPS/ORGANIZATIONS THAT ARE FILING CLAIMS ON BEHALF OF ACTIVE PHYSICIANS (PURSUANT TO SECTION A OF THE CLAIM FORM)

Physician Group/Organization

Physician Group or Organization Name	
Name and Title of Employee/Representative Filing	*Phone*

List of Active Physician Names and Key Information, For <u>Each</u> Active Physician for Whom You Are Submitting Claims:*

Physician Name	Physician Type (MD or DO)	Last four digits of Social Security No.	Range of Gross Receipts (e.g., "Under $5,000" or "Over $50,000")

* Please attach additional pages of this form, if necessary.