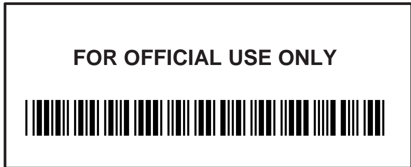
MUST BE POSTMARKED ON OR BEFORE SEPTEMBER 21, 2020

In re Loestrin Fe Antitrust Litigation
Case No. 1:13-md-02472 (D. Rhode Island)

FOR OFFICIAL USE ONLY



THIRD-PARTY PAYOR PROOF OF CLAIM AND RELEASE

Use Blue or Black Ink Only

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

PART I – CLAIMANT IDENTIFICATION

SECTION A		SECTION B
ONLY IF YOU ARE FILING AS A CLASS MEMBER FOR YOUR COMPANY'S HEALTH PLAN	**OR**	ONLY IF YOU ARE AN AUTHORIZED AGENT FILING ON BEHALF OF ONE OR MORE CLASS MEMBERS

Section A: Company or Health Plan Class Member Only

Company or Health Plan Name

Contact Name

Address 1

Address 2

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Tax Identification Number

Email Address

List other names by which your company or health plan has been known or other Federal Employer Identification Numbers ("FEINs") it has used since September 1, 2009.

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

☐ Other (Explain)

Section B: Authorized Agent Only

** As an Authorized Agent, please check how your relationship with the 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

Area Code - Telephone Number

Authorized Agent's Tax Identification Number

Email Address

Please list the name and FEIN of every 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 Proof of Claim as necessary). Alternatively, you may submit the requested list of Class Member names and FEINs in an electronic format, such as Excel or a tab-delimited text file saved on a disk. Please contact the Settlement Administrator to determine what formats are acceptable.

CLASS MEMBER'S NAME	CLASS MEMBER'S FEIN

PART II – AMOUNT CLAIMED

Please type or print in the box below, the total amount paid or reimbursed for Loestrin 24 Fe and/or its AB-rated generic equivalents in any form, and/or Minastrin 24 Fe and/or its AB-rated generic equivalents in any form from September 1, 2009 through and until September 17, 2019, net of co-pays, deductibles, and co-insurance in the United States and its territories, other than for resale.

Note that this Settlement excludes all federal and state governmental entities, but includes cities, towns, or municipalities with self-funded prescription drug plans.

	TOTAL AMOUNT PAID
Purchases or Reimbursements from September 1, 2009 through and until September 17, 2019 for Loestrin 24 Fe, Minastrin 24 Fe and/or their AB-rated generic equivalents in the United States and its territories.	$

You must submit claims data and information in support of the purchase amounts stated above if your total net claim amount is more than $300,000. Instructions on how to do so are found in the Claims Documentation Instructions on Page 1. If your total net claim is $300,000 or less, you need not provide complete claims data with this Claim Form, but the Settlement Administrator may require supporting documentation.

PART III – CERTIFICATION

I (We) have read and am (are) familiar with the contents of the Instructions accompanying this Claim Form. I (We) certify that the information I (we) have set forth in the above Proof of Claim and in any documents attached by me (us) are true, correct and complete to the best of my (our) knowledge. I (We) certify that I (we), or the Class Member(s) I (we) represent, paid the total amount set forth above in out-of-pocket expenditures for purchases or reimbursements Loestrin 24 Fe, Minastrin 24 Fe and/or their AB-rated generic equivalents in the United States and its territories from September 1, 2009 through and until September 17, 2019. I (We) further certify that I (we), or the Class Member(s) I (we) represent, did not opt out of the certified Class in this Action. Nor did I (we), or the represented Class Member(s), purchase such Loestrin 24 Fe, Minastrin 24 Fe and/or their AB-rated generic equivalents for purposes of resale. In addition, I (we) have not (or the represented Class Member(s) has not) served as counsel, officer, director, agent, or employee of the Defendants, or a corporate parent, subsidiary, affiliate, or other related entity thereof; or served as a judge or justice assigned to hear any aspect of this lawsuit.

To the extent I (we) have been given authority to submit this Proof of Claim by a Class Member(s) on its behalf, and accordingly am (are) submitting this Proof of Claim in the capacity of an Authorized Agent with authority to submit it by the Class Member(s) identified on a separate sheet of paper submitted with this form, and to the extent I (we) have been authorized to receive payment on behalf of this Class Member(s), in the event amounts from the Settlement Fund are distributed to me (us) and a Class Member(s) later claims that I (we) did not have authority to claim and/or receive such amounts on its behalf, I (we) and/or my (our) employer will hold the Class, counsel for the Class, and the Settlement Administrator harmless with respect to any claims made by the Class Member(s).

I (We) hereby submit to the jurisdiction of the United States District Court for the District of Rhode Island for all purposes connected with the Proof of Claim, including resolution of disputes relating to this Proof of Claim. I (we) acknowledge that any false information or representations contained herein may subject me (us) to sanctions, including the possibility of criminal prosecution. I (we) agree to supplement this Proof of Claim by furnishing documentary backup for the information provided herein, upon request of the Settlement Administrator.

I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Proof of Claim form was executed this ________ day of ____________________, 2020.

Signature	Position/Title

Print Name	Date

Mail the completed Claim Form, along with any supporting documentation as described on page 2 of the Claim Documentation Instructions, postmarked on or before **September 21, 2020** to:

Loestrin 24 Fe Settlement
c/o A.B. Data, Ltd.
P.O. Box 173085
Milwaukee, WI 53217

Toll-Free Telephone: 1-877-324-0380 Website: www.InReLoestrin24FeAntitrustLitigation.com

REMINDER CHECKLIST:

1. Please complete and sign the above Proof of Claim form. Attach or upload any documentation supporting your claim.
2. Keep a copy of your Proof of Claim form and supporting documentation for your records.
3. If you would also like acknowledgement of receipt of your Proof of 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 (the addresses are listed above).