CLASS ACTION SETTLEMENT CLAIM FORM

IMPORTANT: You have been identified as a claimant who is likely a Class Member.

If you are a self-funded payer that was a citizen of California on January 6, 2015, or a state or local governmental entity of the State of California**, and you compensated Sutter for any anesthesia services other than conscious sedation at any time from January 1, 2003 to December 31, 2013** you may complete this Claim Form to be eligible to receive a cash payment under the Settlement.

Please read the accompanying Settlement Notice before you complete this Claim Form. To participate in this Settlement, your Claim Form must be completed to the best of your ability, signed, and then submitted by **June 09, 2025**, if completed online at www.SutterAnesthesiaBillingLawsuit.com. If your Claim Form is submitted by U.S. mail, it must be postmarked no later than the Claims Deadline of **June 09, 2025**, to the Claims Administrator at Sutter Anesthesia Billing Lawsuit Settlement, c/o JND Legal Administration, P.O Box 91208, Seattle, WA 98111.

Payments under the Settlement will be determined *pro rata* based on the cumulative total of annual active participants in your health plan located in California for each year from 2003 through 2013. Active participants are those individuals who were employed at the end of the plan year and covered by the plan. If all your active participants are in California, this number is identified in your Form 5500, line 6a (2), or Form 5500-SF, line 5b. If you no longer have your active participant information for a particular year between 2003 and 2013, you may still submit this Claim Form, however, payment is based on the total number of active participants listed below.

Please refer to Settlement Notice Question No. 3 for more information about who qualifies as a Class Member.

SECTION I: CONTACT INFORMATION		
Name of Plan		
Street Address		
City	**State**	**Zip Code**
Email Address	**Phone Number**	

SECTION II: ACTIVE PLAN PARTICIPANT INFORMATION 2003-2013	
Please provide how many active participants in your health plan were living in California for each year between 2003 through 2013. If all your active participants are in California, this number is identified in your Form 5500, line 6a (2), or Form 5500-SF, line 5b. If you had no active participants in California, or do not have information to support the number of participants, for a particular year, please enter zero ("0").	
2003	
2004	
2005	
2006	
2007	
2008	

2009	
2010	
2011	
2012	
2013	
TOTAL	

SECTION II: AFFIRMATION

I hereby affirm each of the following under penalty of perjury:

- I am submitting this form on behalf of a self-funded payer that was a citizen of California on January 6, 2015, or a state or local governmental entity of the State of California.
- The self-funded payer made one or more payments to compensate a Sutter hospital for anesthesia services, other than conscious sedation, between January 1, 2003, and December 31, 2013.
- The active participant information listed in Section II is derived from supporting documentation. I understand I may be requested to provide the supporting documentation in support of this claim.
- The information provided in this Claim Form is true and correct to the best of my knowledge.
- I understand that the amount I receive will be calculated according to the terms of the Settlement and that payments will be distributed after the Court grants "final approval" of the Settlement and after all appeals are resolved.
- I understand that claims will not be paid if the value is less than $100.00.

Signature **Date**

Unique ID