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CLAIM FORM FOR SALUD DATA SECURITY INCIDENT BENEFITS

Salud Family Health Data Security Incident Litigation
(*Alexander et al. v. Salud Family Health, Inc.*, Case No. 2023CV30580, 19th District Court, County of Weld, State of Colorado)

USE THIS FORM TO MAKE A CLAIM FOR COMPENSABLE LOST TIME, FOR CREDIT MONITORING AND INSURANCE SERVICES, AND/OR FOR A DOCUMENTED LOSS PAYMENT

Para una notificación en Español, llamar 1-888-608-5913 o visitar nuestro sitio web www.SaludClassAction.com.

The DEADLINE by which this Claim Form must be either electronically filed on the settlement website or postmarked is December 12, 2023.

I. GENERAL INSTRUCTIONS

If you are an individual who was notified that your Personal Information was potentially compromised as a result of a data security incident that was reported on November 4, 2022 (the "Data Security Incident"), by Salud Family Health, Inc. ("Salud"), you are a Class Member.

As a Class Member, you are eligible to make a claim for **one or more** of the following options:

(A) Cash payments of up to $7,500.00 per Class Member for reimbursement of certain Documented Losses ("Documented Loss Payment");

AND/OR

(B) Two years of Credit Monitoring and Insurance Services;

AND/OR

(C) Reimbursement for up to four (4) hours of time spent in connection with the Data Security Incident, compensable at a rate of $20 per hour ("Compensable Lost Time Payment").

The Credit Monitoring and Insurance Services will include the following services, among others: (i) up to $1,000,000 of identity theft insurance coverage; and (ii) two years of three-bureau credit monitoring. If you already enrolled in the free credit monitoring and identify fraud protection services made available by Salud following the Data Security Incident, or from another provider obtained as a result of the Data Security Incident, you will have the option to postpone the commencement of the Credit Monitoring and Insurance Services by up to 24 months for no additional charge.

Documented Loss Payments and Compensable Lost Time Payments are subject to an aggregate cap of $1,000,000 and may be reduced or increased pro rata (equal share) depending on how many Class Members submit claims. Complete information about the Settlement and its benefits are available at www.SaludClassAction.com.

Please complete this Claim Form on behalf of the individual who received a notification from Salud. If you are the parent of a minor who received a Data Security Incident notification, please submit the form using the minor's personal information.

This Claim Form may be submitted online at www.SaludClassAction.com or completed and mailed to the address below. Please type or legibly print all requested information, in blue or black ink. Mail your completed Claim Form, including any supporting documentation, by U.S. Mail to the following address:

Salud Family Health Claims Administrator
P.O. Box 2287
Portland, OR 97208-2287

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II. CLAIMANT INFORMATION

The Claims Administrator will use this information for all communications regarding this Claim Form and the Settlement. If this information changes prior to distribution of cash payments and Credit Monitoring and Insurance Services, you must notify the Claims Administrator in writing at the address above.

First Name | MI | Last Name

Alternative Name(s)

Mailing Address, Line 1: Street Address/P.O. Box

Mailing Address, Line 2

City | State | ZIP Code

Telephone Number

– –

Email Address

Date of Birth (mm–dd–yyyy) | Unique ID Number Provided on Mailed Notice (if known)

– –

☐ Please check this box if you are a parent or guardian submitting this claim on behalf of a minor.

You may select ONE OR MORE of the following options:

III. COMPENSABLE LOST TIME

☐ If you wish to receive a Compensable Lost Time Payment, you must check off the box for this section and select the amount of time you spent, and then simply return this Claim Form.

☐ **1 hour** ☐ **2 hours** ☐ **3 hours** ☐ **4 hours**

You will receive an email at the email address provided above after the Court grants Final Approval of the Settlement prompting you to select how you would like to be paid. You can receive payment via a digital payment, or you can elect to receive a check.

AND/OR

IV. CREDIT MONITORING AND INSURANCE SERVICES

☐ If you wish to receive Credit Monitoring and Insurance Services, you must check off the box for this section, provide your email address in the space provided in Section II, above, and return this Claim Form. Submitting this Claim Form will not automatically enroll you into Credit Monitoring and Insurance Services. To enroll, you must follow the instructions sent to your email address after the Settlement is approved and becomes final (the "Effective Date").

AND/OR

V. REIMBURSEMENT FOR DOCUMENTED LOSSES

☐ Please check off this box for this section if you are electing to seek reimbursement for up to $7,500 of Documented Losses you incurred that are more likely than not incurred as a result of the Salud Data Security Incident and not otherwise reimbursable by insurance. Documented Losses include unreimbursed losses and consequential expenses that are more likely than not incurred as a result of the Salud Data Security Incident and incurred on or after September 5, 2022.

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In order to make a claim for a Documented Loss Payment, **you must** (i) fill out the information below and/or on a separate sheet submitted with this Claim Form; (ii) sign the certification at the end of this Claim Form (section VII); and (iii) include Reasonable Documentation supporting each claimed cost along with this Claim Form. Documented Losses need to be deemed more likely than not incurred as a result of the Salud Data Security Incident by the Claims Administrator based on the documentation you provide and the facts of the Salud Data Security Incident. **Failure to meet the requirements of this section may result in your claim being rejected by the Claims Administrator.**

Cost Type and Examples of Documents	Approximate Date of Loss	Amount of Loss	Description of Loss or Money Spent and Supporting Documents
Unreimbursed fraud losses or charges. Examples: *Account statement with unauthorized charges highlighted; Correspondence from financial institution declining to reimburse you for fraudulent charges.*	MM – DD – YY	$ •	
Professional fees incurred in connection with identity theft or falsified tax returns. Examples: *Receipt for hiring service to assist you in addressing identity theft; Accountant bill for re-filing tax return.*	MM – DD – YY	$ •	
Lost interest or other damages resulting from a delayed state and/or federal tax refund in connection with fraudulent tax return filing. Examples: *Letter from IRS or state about tax fraud in your name; Documents reflecting length of time you waited to receive your tax refund and the amount.*	MM – DD – YY	$ •	
Credit freeze. Examples: *Notices or account statements reflecting payment for a credit freeze.*	MM – DD – YY	$ •	
Credit monitoring that was ordered after September 5, 2022, through the date on which the credit monitoring and insurance services become available through this Settlement. Examples: *Receipts or account statements reflecting purchases made for credit monitoring and insurance services*	MM – DD – YY	$ •	
Miscellaneous expenses such as notary, fax, postage, copying, mileage, and long-distance telephone charges. Examples: *Phone bills, gas receipts, postage receipts; detailed list of locations to which you traveled (e.g., police station, IRS office), indication of why you traveled there (e.g., police report or letter from IRS re: falsified tax return), and number of miles you traveled to remediate or address issues related to the Salud Data Security Incident.*	MM – DD – YY	$ •	
Other (provide detailed description or a separate document submitted with this form).	MM – DD – YY	$ •	

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VI. ATTESTATION

(REQUIRED FOR DOCUMENTED LOSS PAYMENT CLAIMS ONLY)

☐ Check this box to attest that I suffered the Documented Losses claimed above.

VII. CERTIFICATION

By submitting this Claim Form, I certify that I am eligible to make a claim in this Settlement and that the information provided in this Claim Form and any attachments are true and correct. I declare under penalty of perjury under the laws of the State of Colorado that the foregoing is true and correct. I understand that this claim may be subject to audit, verification, and Court review and that the Claims Administrator may require supplementation of this Claim or additional information from me. I also understand that all claim payments are subject to the availability of settlement funds and may be reduced in part or in whole, depending on the type of claim and the determinations of the Claims Administrator.

Signature

Print Name

Date: MM – DD – YYYY