

Your claim must be submitted online or postmarked by: June 8, 2026

*DeCostanzo v. GlaxoSmithKline plc et al.*  
Case No. 2:21-cv-4869-NJC-AYS  
United States District Court, Eastern District of New York

**BOOSTRIX  
CLAIM**

## CLAIM FORM

### GENERAL INSTRUCTIONS FOR SETTLEMENT CLASS MEMBERS

Anyone who believes they are eligible to receive a payment as part of the settlement of the *DeCostanzo v. GlaxoSmithKline plc et al.* litigation must complete this claim form in order to receive a payment. For the claim form to be valid, the eligible Settlement Class Member must complete all five (5) sections.

#### Who is an Eligible Settlement Class Member?

The **Eligible Settlement Class Members** include: All adults who viewed the **Advertising Campaign**, and either lived in New York at the time, or were vaccinated with **BOOSTRIX** in New York, and were vaccinated with **BOOSTRIX** during the **Class Period** in order to protect one or more other individuals from pertussis.

The **Advertising Campaign** was the GSK multimedia advertising campaign that ran between 2015 and 2020 concerning pertussis, also known as “whooping cough,” in which each advertisement featured one or more humanized wolves, and was known as the “Big Bad Cough” campaign.

**BOOSTRIX** is a tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis (Tdap) vaccine developed and manufactured by GSK.

The **Class Period** refers to the time period from May 20, 2016, through May 20, 2020.

**Excluded from the Settlement Class are:** (i) any woman who was vaccinated with BOOSTRIX while pregnant; (ii) GSK, its officers, directors, affiliates, legal representatives, employees, successors, and assigns, and entities in which GSK has a controlling interest; (iii) judges presiding over the Litigation; (iv) counsel of record for the Parties; and (v) all Persons who validly opt-out in a timely manner.

#### What Monetary Relief Can Eligible Settlement Class Members Receive?

Only one (1) Claim may be filed per Settlement Class Member.

Eligible Claimants who submit a complete Claim Form with Attestation of Vaccination demonstrating a valid Claim **with Qualifying Proof of Vaccination** shall be paid a total of \$50.00.

Eligible Claimants who submit a complete Claim Form with Attestation of Vaccination demonstrating a valid Claim **without Qualifying Proof of Vaccination** shall be paid a total of \$10.00.

**Qualifying Proof of Vaccination** means, with respect to any Settlement Class Member’s qualifying vaccination with BOOSTRIX during the Class Period:

- (i) appropriate documentary records created by the health care provider or pharmacy that administered the subject vaccination to the Settlement Class Member that reflect the vaccination with BOOSTRIX during the Class Period;
- (ii) appropriate documentary records created by the insurer covering the Settlement Class Member with regard to the subject vaccination that reflect the vaccination with BOOSTRIX; or
- (iii) any other satisfactory medical documentation of the vaccination with BOOSTRIX created before February 10, 2025 by a third party that recorded the date and type of vaccination administered to the Settlement Class Member (*e.g.*, medical records maintained by a hospital or a primary care physician).

#### How You Can Submit A Claim?

Mail your completed Claim Form along with supporting documentation to: **Big Bad Cough Settlement, Attn: Claim Forms, 1650 Arch Street, Suite 2210, Philadelphia, PA 19103.** Do not include original copies of your supporting documentation, as the documentation will not be returned to you.

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Alternatively, you may complete and submit your Claim Form online at [www.BigBadCoughSettlement.com](http://www.BigBadCoughSettlement.com).

### I. SETTLEMENT CLASS MEMBER NAME AND CONTACT INFORMATION

Provide your name and contact information below. You must notify the Settlement Administrator if your contact information changes after you submit this Claim Form.

**First Name**

**Last Name**

**Street Address**

**City**

**State**

**Zip Code**

**Email Address**

**Telephone Number**

### II. STATEMENTS ABOUT YOUR BOOSTRIX VACCINATION

Check each box that is an accurate statement about your Boostrix vaccination. By checking a box, you are swearing under penalty of perjury that the statement is true and correct.

- I was vaccinated with BOOSTRIX during the Class Period after seeing one or more advertisements in the Advertising Campaign.
- I was vaccinated with BOOSTRIX (rather than a different Tdap vaccine with a different brand name), during the Class Period.
- I lived in New York at the time of the subject vaccination with BOOSTRIX and/or received the subject vaccination with BOOSTRIX in New York.
- I received the subject vaccination with BOOSTRIX in order to protect one or more other individuals against pertussis.
- I did **not** receive the subject vaccination with BOOSTRIX while pregnant in order to protect my fetus (through maternal immunization).

### III. SPECIFIC DETAILS ABOUT YOUR BOOSTRIX VACCINATION

Please provide all of the information requested below:

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**CLAIM FORM**

1. The approximate date of your BOOSTRIX vaccination (MM/YYYY): \_\_\_ / \_\_\_ - \_\_\_ - \_\_\_
2. The location of your BOOSTRIX vaccination: City: \_\_\_\_\_ State: \_\_\_
3. The name of the medical practice or pharmacy that administered your BOOSTRIX vaccination: \_\_\_\_\_
4. The name(s) of the specific individual(s) whom you sought to protect from pertussis through your BOOSTRIX vaccination: \_\_\_\_\_

**Select from one of the following:**

- I am submitting my Qualifying Proof of Vaccination with this Claim Form (see “Monetary Relief” section above).
- I am submitting only this Claim Form with Attestation of Vaccination without Qualifying Proof of Vaccination.

**IV. PAYMENT SELECTION**

Please select **one** of the following payment options:

**Venmo** - Enter the mobile number associated with your Venmo account: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Zelle** - Enter the mobile number or email address associated with your Zelle account:

Mobile Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ or Email Address: \_\_\_\_\_

**Virtual Prepaid Card** - Enter your email address: \_\_\_\_\_

**Physical Check** - Payment will be mailed to the address provided in Section I above.

**V. AFFIRMATION & SIGNATURE**

I swear and affirm under penalty of perjury pursuant to laws of the United States of America to the following:

- The information provided in this Claim Form, including any Qualifying Proof of Vaccination submitted in support of this Claim Form, is true and correct to the best of my knowledge.
- I understand that my claim is subject to verification and that I may be asked to provide supplemental information by the Settlement Administrator before my claim is considered complete and valid.
- By signing and submitting this Claim Form, I agree to be bound by the Release set forth in the Settlement Agreement and the Court’s Final Judgment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date