Claimant Information

PROVIDE YOUR CONTACT INFORMATION:

Name: _____ Phone: (____) _____

Address: _____

City: _____ State: _____ Zip Code _____

Phone number: (____) _____

Email Address: _____

Cigna Member ID #: _____

Cigna Claim ID # _____

Balance Bill Information and Documentation

To obtain a payment from the settlement, you must provide proof of a balance bill for the claim with the unique claim ID you received in the letter accompanying your notice form. Please note that a balance bill is a bill for the difference between the provider's billed charge and the allowed amount determined by Cigna. This bill would be different than your copayments, coinsurance, and deductible payments. If your provider honored the in-network treatment of the claim, you should **NOT** have received a balance bill.

You can do this in one of two ways.

1. You can provide proof of payment of a balance bill, including any interest, penalties, or debt collection fees incurred in connection with the balance bill to the extent you have incurred and seek to recover interest charges, debt collection fees, or penalties directly related to a balance bill; or

2. If you have not yet paid the balance bill, you can submit a signed affirmation that you will use the settlement payment solely to satisfy the balance bill, including any applicable interest, penalties, or debt collection fees, by paying either (i) the healthcare provider or (ii) a debt collector or assignee who holds the balance bill, and you agree to hold Cigna harmless for all liability arising from non-payment of the balance bill, including interest, debt collection fees, and penalties.

Please mail or email this information to the Settlement Administrator at the below address:

Cigna LocalPlus Settlement Administrator
Attn: Claim Forms
1650 Arch Street, Suite 2210
Philadelphia, PA 19103

CERTIFICATION UNDER PENALTY OF PERJURY FOR ALL CLAIMANTS

I hereby certify under penalty of perjury that:

1. I have read the Settlement Agreement and agree to its terms, including the Release(s).

2. The information provided in this Claim Form is accurate and complete to the best of my knowledge, information, and belief.

3. The additional documentation and information provided to the Settlement Administrator to support my Claim is original or else a complete and true copy of the original(s).

4. I am a member of the Settlement Class and did not request to Opt-Out from the Settlement Class.

5. I have not already entered into a Settlement for any of the Claims set forth in this Claim Form.

6. I am neither (a) an officer or director of Cigna; (b) a judicial officer to whom this case is assigned or any member of their staffs and immediate families; (c) an heir, assign, or successor of any of the persons or entities described in parts (a) and (b); nor (d) an individual who has opted-out of the Settlement.

7. I have not submitted any other Claim for the same balance bill and have not authorized any other Person or entity to do so and know of no other Person or entity having done so on my behalf.

8. I will timely provide any additional information requested by the Settlement Administrator to validate my Claim.

9. I understand that by submitting this Claim Form, the effect is the same as if I have given a complete Release of all settled Claims; and

10. I understand that Claims will be audited for veracity, accuracy, and fraud. Claim Forms that are not valid and/or illegible can be rejected.

Signature: _____ Dated: _____

CERTIFICATION UNDER PENALTY OF PERJURY FOR CLAIMANTS WHO DID NOT PAY THEIR BALANCE BILL BUT WILL USE THE SETTLEMENT FUNDS TO PAY IT.

I hereby certify under penalty of perjury that:

1. I have received a balance bill from my provider for the Cigna claim ID identified in my claim form.

2. I have not paid my provider for that balance bill for this claim.

3. When I receive compensation from the settlement, I will use those funds to pay the provider, debt collector, or assignee for the balance bill.

4. To the fullest extent permitted by law, I shall indemnify, defend, and hold Cigna harmless from and against any and all claims, damages, losses and expenses, including but not limited to court costs, attorney's fees and alternative dispute resolution costs, resulting from any failure to use the funds provided by the settlement to compensate my provider, debt collector or assignee for the balance bill.

Signature: _____ Dated: _____