Your claim must be submitted online or postmarked by: October 22, 2024

East River Medical Imaging Data Security Incident Litigation
Guarnaschelli, et al. v. East River Medical Imaging, P.C.
Index No. 656099/2023 (Sup. Ct., NY Cty.)

CLAIM FORM FOR EAST RIVER MEDICAL IMAGING DATA SECURITY INCIDENT BENEFITS

ERMI

USE THIS FORM TO MAKE A CLAIM FOR CREDIT MONITORING AND INSURANCE SERVICES; FOR A DOCUMENTED LOSS PAYMENT; OR FOR AN ALTERNATIVE CASH FUND PAYMENT

The DEADLINE to submit this Claim Form is: October 22, 2024
Claim Forms must be postmarked or submitted electronically by that date.

GENERAL INSTRUCTIONS

If you are an individual who was notified that you are a Class Member of a Settlement that was reached as a result of a Data Incident that occurred when files at the East River Medical Imaging, P.C. ("ERMI") computer systems were accessed by an unauthorized person (the "Data Security Incident"), you are a Class Member.

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

(1) up to a $7,500.00 cash payment for reimbursement of Documented Losses that are more likely than not a result of the East River Medical Imaging Data Security Incident ("Documented Loss Payment");

OR

(2) a *pro rata* Cash Fund Payment, the amount of which will depend on the number of Class Members who participate in the Settlement and submit valid and Approved Claims for CMIS and Documented Loss Payments.

Also, Class Members will be entitled to claim one year of Credit Monitoring and Insurance Services and $1 million in insurance ("CMIS").

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) one year of three-bureau credit monitoring providing, among other things, notice of changes to the Class Member's credit profile. If you file a claim for Credit Monitoring and Insurance Services, you will receive an enrollment code – valid for 365 days after the Effective Date of the Settlement – that can be used to enroll in the service.

Cash Fund Payments 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.EastRiverSettlement.com.

This Claim Form should be completed by the individual who received a notification from ERMI, or someone legally authorized to act on behalf of the individual who received a notification from ERMI.

This Claim Form may be submitted online at www.EastRiverSettlement.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:

East River Medical Imaging Data Security Incident Litigation,
c/o Settlement Administrator
1650 Arch Street, Suite 2210
Philadelphia, PA 19103

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I. CLAIMANT INFORMATION

The Settlement Administrator will use this information for all communications regarding this Claim Form and the Settlement. If this information changes prior to distribution of Cash Fund Payments and Credit Monitoring and Insurance Services, you must notify the Settlement Administrator in writing at the address in the general instructions.

First Name **Last Name**

Street Address

City **State** **Zip Code**

Email Address **Cellular Phone Number** **Home Phone Number**

Date of Birth (MM/DD/YYYY) **Unique ID Number Provided on Mailed or Emailed Notice**

II. CREDIT MONITORING AND INSURANCE SERVICES ("CMIS")

☐ 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 I, 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"). You do not need to submit any additional documents if you are electing this category, so long as you provide your Unique ID Number that was provided on your mailed or emailed Notice.

You may select ONE of the following options:

CASH FUND PAYMENT - *Proceed to Section III*

OR

REIMBURSEMENT FOR DOCUMENTED LOSSES - *Proceed to Section IV*

III. CASH FUND PAYMENT

☐ If you wish to receive a Cash Fund Payment, you must check off the box for this section, and then simply return this Claim Form. You do not need to submit any additional documents if you are electing this category, so long as you provide your Unique ID Number that was provided on your mailed Notice.

IV. 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 a result of the East River Medical Imaging Data Security Incident. Documented Losses include unreimbursed losses and consequential expenses that more likely than not resulted from the East River Medical Imaging Data Security Incident and were incurred between August 31, 2023 and the Claims Deadline.

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 attestation at the end of this Section; and (iii) include Reasonable Documentation supporting each claimed cost along with this Claim Form. Documented Losses need to be deemed more likely than not due to the East River Medical Imaging Data Security Incident by the Settlement Administrator based on the documentation you provide and the facts of the East River Medical Imaging Data Security Incident. **Failure to meet the requirements of this section may result in your claim being rejected by the Settlement Administrator.**

Cost Type (Fill all that apply)	**Approximate Date of Loss**	**Amount of Loss**	**Description of Supporting Reasonable Documentation** (Identify what you are attaching and why)
○ Unreimbursed fraud losses or charges	/ / (mm/dd/yy)	$.	*Examples: Account statement with unauthorized charges highlighted; Correspondence from financial institution declining to reimburse you for fraudulent charges.*
○ Professional fees incurred in connection with identity theft or falsified tax returns	/ / (mm/dd/yy)	$.	*Examples: Receipt for hiring service to assist you in addressing identity theft; Accountant bill for re-filing tax return.*
○ Lost interest or other damages resulting from a delayed state and/or federal tax refund in connection with	/ / (mm/dd/yy)	$.	*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.*

Cost Type (Fill all that apply)	**Approximate Date of Loss**	**Amount of Loss**	**Description of Supporting Reasonable Documentation** (Identify what you are attaching and why)
fraudulent tax return filing.			
○ Credit freeze.	/ / (mm/dd/yy)	$.	*Examples: Notices or account statements reflecting payment for a credit freeze.*
○ Credit monitoring that was ordered after August 31, 2023 through the date on which the Credit Monitoring and Insurance Services become available through this Settlement.	/ / (mm/dd/yy)	$.	*Examples: Receipts or account statements reflecting purchases made for credit monitoring and insurance services.*
○ Miscellaneous expenses such as notary, fax, postage, copying, mileage, and long-distance telephone charges	/ / (mm/dd/yy)	$.	*Examples: Phone bills, gas receipts, postage receipts; detailed list of locations to which you traveled (i.e. police station, IRS office), indication of why you traveled there (i.e. police report or letter from IRS re: falsified tax return) and number of miles you traveled to remediate or address issues related to the East River Medical Imaging Data Security Incident .*
○ Other (provide detailed description).	/ / (mm/dd/yy)	$.	*Please provide detailed description below or in a separate document submitted with this Claim Form.*

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Cost Type (Fill all that apply)	**Approximate Date of Loss**	**Amount of Loss**	**Description of Supporting Reasonable Documentation** (Identify what you are attaching and why)
○ Settlement Benefits Related to Emotional Distress. ○ Check this box **<u>only if</u>** you declare that you were a <u>Medicare beneficiary</u> during the time period of August 31, 2023 to the present and are seeking benefits in this Settlement related to emotional distress. If you were a Medicare beneficiary at any time during the period of August 31, 2023 to present and are seeking any reimbursement for emotional distress, please contact the Settlement Administrator at 1-833-622-2291 to provide additional information necessary for Medicare reporting requirements. ***<u>Leave this box unchecked if either</u>*:** (i) you were **<u>not</u>** a Medicare beneficiary during the time period of August 31, 2023 to the present; or (ii) if you were a Medicare beneficiary at any time during the period of August 31, 2023 to the present and are **<u>not</u>** seeking any reimbursement for emotional distress from this Settlement.	☐☐/☐☐/☐☐ (mm/dd/yy)	*$* ☐☐☐☐☐☐.☐☐	*Examples: Bills from medical providers or for medications prescribed for the treatment of emotional distress, anxiety, or other mental health disorders reasonably related to the conditions caused by the Data Security Incident between August 31, 2023 and the Claims Deadline* ***Please attach a copy of your medical bills, pharmacy bills, or an explanation of benefit forms showing the out-of-pocket expenditures for treatment of emotional distress or anxiety.***

ATTESTATION
(REQUIRED FOR DOCUMENTED LOSS PAYMENT CLAIMS ONLY)

I, _____, declare that I suffered the Documented Losses claimed above.
[Name]

I also attest that the Documented Losses claimed above are accurate and were not otherwise reimbursable by insurance.

I declare under penalty of perjury under the laws of New York that the foregoing is true and correct.
Executed on _____, in _____, _____.

[Date] [City] [State]

_____
[Signature]

V. PAYMENT SELECTION

Please select **one** of the following payment options if you seeking a Cash Fund Payment (Section III) or Reimbursement for Documented Losses (Section IV).

☐ **PayPal** - Enter your PayPal email address: _____

☐ **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.

VI. 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 New York that the foregoing is true and correct. I understand that this claim may be subject to audit, verification, and Court review and that the Settlement 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 Settlement Administrator.

_____	_____	_____
Signature	Printed Name	Date