

Your claim must  
be submitted  
online or  
POSTMARKED  
BY: APRIL 29,  
2026

**CLAIM FORM FOR MCLAREN HEALTH CARE CORPORATION**  
**DATA BREACH BENEFITS**

**McLaren Health Care Corporation Data Breach Litigation**

*Cindy Womack-Devereaux, et al. v. McLaren Health Care Corporation,*  
Case No. 24-121459 (Genesee Cnty. Cir. Ct.)

**MCL  
CLAIM**

**USE THIS FORM TO MAKE A CLAIM FOR CREDIT MONITORING AND IDENTITY THEFT PROTECTION, AND FOR ONE OR BOTH OF (1) A DOCUMENTED LOSS PAYMENT AND (2) AN ALTERNATIVE FLAT CASH (PRO RATA) PAYMENT**

**The DEADLINE to submit this Claim Form is postmarked: April 29, 2026**

**I. GENERAL INSTRUCTIONS**

If you are a natural person whose Private Information may have been compromised as a result of one of the Data Breaches occurring between July 28, 2023 through August 23, 2023, and between July 17, 2024 and August 3, 2024, including those who were sent a notice by McLaren Health Care Corporation of either of the Data Breaches, you are a Class Member.

As a Class Member, you are eligible to make a claim for a cash payment and for credit monitoring.

For the cash payment, you may make a claim for the following options:

(1) up to a \$5,000 cash payment for reimbursement of Documented Losses supported by Reasonable Documentation that occurred on or after July 28, 2023, are more likely than not a result of one of the Data Breaches, and were not otherwise reimbursed by another source;

AND

(2) a flat, pro rata cash payment (Cash Fund Payment), the amount of which will depend on the number of Class Members who participate in the Settlement and how much of the Settlement Fund remains after payment of valid Documented Loss Payment claims.

In addition to a cash payment, all Class Members are *also* eligible to elect Credit Monitoring and Identity Theft Protection (“Credit Monitoring”) services. The Credit Monitoring benefit will include one year of one bureau medical monitoring and identity theft protection. All Class Members who elect to receive the Credit Monitoring benefit will receive an enrollment code that can be used to enroll in the service. If you elect Credit Monitoring and already maintain a credit monitoring service, you may elect to defer your enrollment in the Credit Monitoring for a period of 12 months.

Complete information about the Settlement and the Settlement Benefits is available at [www.MHCCSettlement.com](http://www.MHCCSettlement.com).

This Claim Form may be submitted online at [www.MHCCSettlement.com](http://www.MHCCSettlement.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:



Your claim must  
be submitted  
online or  
POSTMARKED  
BY: APRIL 29,  
2026

**CLAIM FORM FOR MCLAREN HEALTH CARE CORPORATION**  
**DATA BREACH BENEFITS**

**McLaren Health Care Corporation Data Breach Litigation**

*Cindy Womack-Devereaux, et al. v. McLaren Health Care Corporation,*  
Case No. 24-121459 (Genesee Cnty. Cir. Ct.)

**MCL  
CLAIM**

**IV. CREDIT MONITORING AND IDENTITY THEFT PROTECTION SERVICES**

All Class Members are eligible to elect the Credit Monitoring Settlement Benefit.

If you wish to receive Credit Monitoring, you must check this box. Submitting this Claim Form will not automatically enroll you into the Credit Monitoring Settlement Benefit. To enroll, you must follow the instructions sent to your email address after the Settlement is approved and becomes final. **Enrollment instructions will be emailed to the email address provided in Section II above.**

**V. REQUEST FOR CASH PAYMENT OR REIMBURSEMENT**

**You may select one or both of the following options:**

**A. Cash Fund Payment**

If you wish to receive a flat pro rata Cash Fund Payment, you must check off this box and then simply return this Claim Form.

**AND/OR**

**B. Reimbursement for Documented Losses**

Please check this box if you are electing to seek reimbursement for documented losses, of up to \$5,000, you incurred that are more likely than not traceable to the Data Breaches and not otherwise reimbursed by any other source. Documented Losses include unreimbursed losses and consequential expenses that are more likely than not related to the Data Breaches and incurred on or after July 28, 2023.

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 Claim Form (section VIII); 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 Data Breaches by the Settlement Administrator based on the documentation you provide. **Failure to meet the requirements of this section may result in your claim being rejected by the Settlement Administrator. If your claim for a Documented Loss Payment is rejected and you fail to cure the defect, your claim will automatically be considered as a claim for a Cash Fund Payment.**

Your claim must  
be submitted  
online or  
POSTMARKED  
BY: APRIL 29,  
2026

**CLAIM FORM FOR MCLAREN HEALTH CARE CORPORATION**  
**DATA BREACH BENEFITS**

MCL  
CLAIM

**McLaren Health Care Corporation Data Breach Litigation**

*Cindy Womack-Devereaux, et al. v. McLaren Health Care Corporation,*  
Case No. 24-121459 (Genesee Cnty. Cir. Ct.)

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)
<input type="radio"/> Unreimbursed fraud losses or charges	[ ] / [ ] / [ ] (mm/dd/yy)	\$ [ ] [ ] [ ] [ ]. [ ] [ ]	<i>Examples: Account statement with unauthorized charges highlighted; Correspondence from financial institution declining to reimburse you for fraudulent charges</i>
<input type="radio"/> Professional fees incurred in connection with identity theft or falsified tax returns	[ ] / [ ] / [ ] (mm/dd/yy)	\$ [ ] [ ] [ ] [ ]. [ ] [ ]	<i>Examples: Receipt for hiring service to assist you in addressing identity theft; Accountant bill for re-filing tax return</i>
<input type="radio"/> Lost interest or other damages resulting from a delayed state and/or federal tax refund in connection with fraudulent tax return filing	[ ] / [ ] / [ ] (mm/dd/yy)	\$ [ ] [ ] [ ] [ ]. [ ] [ ]	<i>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</i>
<input type="radio"/> Credit freeze	[ ] / [ ] / [ ] (mm/dd/yy)	\$ [ ] [ ] [ ] [ ]. [ ] [ ]	<i>Examples: Notices or account statements reflecting payment for a credit freeze</i>

**Your claim must  
be submitted  
online or  
POSTMARKED  
BY: APRIL 29,  
2026**

**CLAIM FORM FOR MCLAREN HEALTH CARE CORPORATION  
DATA BREACH BENEFITS**

**MCL  
CLAIM**

**McLaren Health Care Corporation Data Breach Litigation**

***Cindy Womack-Devereaux, et al. v. McLaren Health Care Corporation,  
Case No. 24-121459 (Genesee Cnty. Cir. Ct.)***

<b>Cost Type (Fill all that apply)</b>	<b>Approximate Date of Loss</b>	<b>Amount of Loss</b>	<b>Description of Supporting Reasonable Documentation (Identify what you are attaching and why)</b>
<input type="radio"/> Credit monitoring that was ordered after July 28, 2023 through the date on which the Credit Monitoring and Insurance Services becomes available through this Settlement	____ / ____ / ____ (mm/dd/yy)	\$ ____ . ____	<i>Example: Receipts or account statements reflecting purchases made for credit monitoring and insurance services</i>
<input type="radio"/> Miscellaneous expenses such as notary, fax, postage, copying, and mileage	____ / ____ / ____ (mm/dd/yy)	\$ ____ . ____	<i>Example: 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 Data Breaches</i>
<input type="radio"/> Other (provide detailed description)	____ / ____ / ____ (mm/dd/yy)	\$ ____ . ____	<i>Please provide detailed description below or in a separate document submitted with this Claim Form.</i>

**Your claim must  
be submitted  
online or  
POSTMARKED  
BY: APRIL 29,  
2026**

**CLAIM FORM FOR MCLAREN HEALTH CARE CORPORATION  
DATA BREACH BENEFITS**

**MCL  
CLAIM**

**McLaren Health Care Corporation Data Breach Litigation**

***Cindy Womack-Devereaux, et al. v. McLaren Health Care Corporation,*  
Case No. 24-121459 (Genesee Cnty. Cir. Ct.)**

**VI. 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 my home state that the foregoing is true and correct.

Executed on \_\_\_\_\_, in \_\_\_\_\_, \_\_\_\_\_.  
[Date] [City] [State]

\_\_\_\_\_ [Signature]

**VII. PAYMENT SELECTION**

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

PayPal  Venmo  Zelle  Virtual Prepaid Card  Check\*

Please provide the email address or phone number associated with your PayPal, Venmo or Zelle account, or email address for the Virtual Prepaid card: \_\_\_\_\_

*\*Payment will be mailed to the address provided in Section II of this Claim Form. If no option is selected, payment will be mailed.*

**VIII. 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 my home state 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.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_