Exhibit E

Your claim must be submitted online or **postmarked by:** [DEADLINE]	**IN RE: AMERICAN MEDICAL COLLECTION AGENCY, INC. CUSTOMER DATA SECURITY BREACH LITIGATION SONIC HEALTHCARE U.S.A., AURORA DIAGNOSTICS LLC, CLINICAL PATHOLOGY LABORATORIES, INC., AND AUSTIN PATHOLOGY ASSOCIATES SETTLEMENT** Civil Action No. 19-md-2904 (JKS)(MAH)(MDL 2904) **CLAIM FORM**	

- up to 10 total hours for verified and documented time spent remedying fraud, identity theft, or other similar misuse of a Settlement Class Member's personal information that is fairly traceable to the AMCA Security Incident at $25 per hour.

This Claim Form may be submitted electronically *via* the Settlement Website at _____ or completed and mailed, including any supporting documentation, to: *American Medical Collection Agency, Inc. Customer Data Security Breach Litigation Sonic Healthcare U.S.A., Aurora Diagnostics LLC, Clinical Pathology Laboratories, Inc., and Austin Pathology Associates Settlement, Attn: Claims*, [ADRESS].

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**

Notice ID Number, if known

II. BENEFIT SELECTION

Select one (1) of the following options:

☐ Check this box if you want to receive the Alternative Cash Payment of up to $50. If you select this option, proceed to the next section.

OR

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☐ Check this box if you want to receive reimbursement for Out-of-Pocket Losses of up to $5,000.*

***You must submit supporting documentation demonstrating that the unreimbursed costs or expenditures that you actually incurred are fairly and reasonably traceable to the AMCA Security Incident.**

Complete the chart below describing the supporting documentation you are submitting.

Cost Type (fill in all that apply)	***Approximate Date of Loss***	***Amount of Loss***	***Description of Documentation Provided***
Example: Credit Repair Service	*07/17/25 (MM/DD/YY)*	*$100*	*Example: Receipt for credit repair services*
		TOTAL AMOUNT CLAIMED:	

III. HEALTHCARE INFORMATION MONITORING SERVICES

☐ Check this box if you wish to receive up to two (2) years of medical and healthcare information monitoring services by CyEx Medical Shield Pro.

IV. ATTESTATION & SIGNATURE

I swear and affirm under penalty of perjury that the information provided in this Claim Form, and any supporting documentation provided 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 or Claims Referee before my claim is considered complete and valid.

Signature	Printed Name	Date