

Exhibit F

Your Claim Form
must be submitted
online or
received by:
[DEADLINE]

Rachel Calcaterra v. Natera, Inc.
Case No. 4:23-cv-06342-YGR (N.D. Cal.)

STR-CLAIM

SETTLEMENT CLAIM FORM

GENERAL INSTRUCTIONS

You are eligible to submit a Claim Form if you are a Settlement Class Member.

The **Settlement Class includes**: All persons in the United States who had noninvasive prenatal testing (NIPT or “Panorama”) or genetic carrier screening (“Horizon”) (collectively, the “Genetic Screening Tests”) performed by Natera, Inc. (“Company”) and were billed more than (i) \$249 for NIPT without microdeletions, (ii) \$349 for NIPT with microdeletions, or (iii) \$349 for genetic carrier screening, between July 10, 2019 through the date of preliminary approval (the “Class Period”).

The **Settlement Class excludes**: (i) persons whose Genetic Screening Test(s) were paid for entirely by insurance (directly or indirectly) or some other third-party source, and were not billed by Company; (ii) persons whose Genetic Screening Test(s) was performed by Company as part of a clinical trial or research study; (iii) any judge or magistrate presiding over the Actions and members of their families; (iv) Company and its subsidiaries, parent companies, successors, predecessors, and any entity in which Company or its parents have a controlling interest, and their current and former officers, directors, and employees; (v) Company’s counsel of record; and (vi) Persons who properly execute and submit a timely request for exclusion in accordance with the Opt-Out Procedure detailed in the Preliminary Approval Order; and the legal representatives, successors or assigns of any such persons.

SETTLEMENT CLASS MEMBER BENEFITS

If you file a valid claim, you will receive a share of the Net Settlement Fund, up to the amount that you paid out-of-pocket to Company more than \$249 or \$349 (depending on the particular Genetic Screening Test(s) you received); or, if you did not pay out-of-pocket to Company more than \$249 or \$349, a maximum of \$50. Please see the Long Form Notice and Settlement Agreement for more details. The amount you receive will also depend on the number of claimants, and therefore cannot be estimated at this time.

Company denies Plaintiffs’ allegations and maintains that its practices complied with applicable laws and standards, and that the overwhelming majority of patients owe less than \$249 or \$349, depending on the test and the details of their individual health plan.

SUBMITTING A CLAIM FORM

You can submit a Claim Form online at [WEBSITE] or by completing and submitting this Claim Form by mail to: Genetic Screening Test Settlement, c/o Kroll Settlement Administration LLC, P.O. Box 225391, New York, NY 10150-539. The deadline to submit your Claim Form online is **DEADLINE**. Otherwise, you must mail your Claim Form, so it is **received by the Settlement Administrator no later than DEADLINE**.

If your Claim Form is incomplete or missing information, the Settlement Administrator may contact you for additional information. If you do not respond and your claim is denied, you will not receive a settlement payment. If you have any questions, please contact the Settlement Administrator by email at info@.com or by mail at the address listed above.

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I. CLAIMANT CONTACT INFORMATION

Provide your contact information below. It is your responsibility to notify the Settlement Administrator of any changes to your contact information after the submission of your Claim Form.

First Name input field

Last Name input field

First Name

Last Name

Street Address input field

Street Address

City input field

State input field

Zip Code input field

City

State

Zip Code

Email Address input field

Phone Number input field

Notice ID Number* input field

Email Address

Phone Number

Notice ID Number*

* If you received a Notice about this Settlement via email, provide the Notice ID number.

II. INFORMATION ABOUT YOUR GENETIC SCREENING TEST

(a) During the period of July 10, 2019 through _____, 2026, did you undergo noninvasive prenatal testing (Panorama™) without microdeletions performed by Company?

- Yes, I did.
No, I did not.

(b) If the answer to the above Question is "Yes", did you receive a bill from Company requesting payment of more than \$249 from you?

- Yes, I received a bill from Company charging over \$249.
No, I did not receive a bill from Company charging over \$249.

(c) If the answer to the above Question is "Yes", did you make an out-of-pocket payment to Company of more than \$249?

- Yes, I paid Company over \$249.
No, I did not pay Company over \$249.

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- (d)** During the period of July 10, 2019 through _____, 2026, did you undergo noninvasive prenatal testing (Panorama™) with microdeletions performed by Company?
- Yes, I did.
- No, I did not.
- (e)** If the answer to the above Question is “Yes”, did you receive a bill from Company requesting payment of more than \$349 from you?
- Yes, I received a bill from Company charging over \$349.
- No, I did not receive a bill from Company charging over \$349.
- (f)** If the answer to the above Question is “Yes”, did you make an out-of-pocket payment to Company of more than \$349?
- Yes, I paid Company over \$349.
- No, I did not pay Company over \$349.
- (g)** During the period of July 10, 2019 through _____, 2026, did you undergo genetic carrier screening (Horizon™) performed by Company?
- Yes, I did.
- No, I did not.
- (h)** If the answer to the above Question is “Yes”, did you receive a bill from Company requesting payment of more than \$349 from you?
- Yes, I received a bill from Company charging over \$349.
- No, I did not receive a bill from Company charging over \$349.
- (i)** If the answer to the above Question is “Yes”, did you make an out-of-pocket payment to Company of more than \$349?
- Yes, I paid Company over \$349.
- No, I did not pay Company over \$349.

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(j) If you made an out-of-pocket payment to Company of more than \$249 and/or \$349 for the Genetic Screening Test(s) performed by Company, please list the amount(s) (this step is not required but will expedite verification of your claim):

Total out-of-pocket amount paid to	\$ _____
Company in excess of \$249 and/or \$349:	\$ _____
	\$ _____
	\$ _____

(k) Please provide the address that was associated with your Company purchase during the period of July 10, 2019 through _____, 2026.

Address: _____

III. PAYMENT SELECTION

To receive a payment from this Settlement via an electronic payment, you must submit the Claim Form electronically at << website>> by <<deadline>>.

For any Settlement Class Member whose Settlement Payment is ten United States Dollars (\$10.00) or more and who does not elect an electronic payment option by the Claim Filing Deadline, the Settlement Administrator shall mail their Settlement Payment by check via U.S. Mail. For any Settlement Class Member whose Settlement Payment is less than ten United States Dollars (\$10.00) and who has not elected an electronic payment option by the Claim Filing Deadline, such Settlement Class member will not receive a Settlement Payment and their Settlement Payment shall be treated as an Unclaimed Amount.

IV. CERTIFICATION & SIGNATURE

BY SIGNING AND SUBMITTING THIS CLAIM FORM, YOU OR YOUR AUTHORIZED REPRESENTATIVE ACTING ON YOUR BEHALF CERTIFY AS FOLLOWS:

- I am a natural person residing in the United States who purchased a Genetic Screening Test performed by Company during the Class Period;
- I have read the Notice and Claim Form, including the descriptions of the Releases provided for in the Settlement Agreements;
- I am a Settlement Class Member and am not one of the individuals or entities excluded from the Settlement Class;
- I received a Genetic Screening Test performed by Company associated with this Claim Form for myself and not as an agent of another, and have not assigned my Settled Claims to another, and have not submitted another claim on my behalf in this Settlement;
- I submit to the jurisdiction of the United States District Court for the Northern District of California with respect to my claim and for purposes of enforcing the Releases set forth in any Judgment(s) that may

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be entered in the Action;

- I agree to furnish any additional information with respect to this Claim Form as the Settlement Administrator or the Court may require, and the failure to do so may result in the denial of my Claim;
- I acknowledge that I will be bound by and subject to the terms of the Judgments that will be entered in the Action if the Settlement is approved; and
- I understand that any trial by jury and any right of appeal or review of the Court’s determination with respect to my Claim are waived.

UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE UNITED STATES OF AMERICA, I CERTIFY THAT ALL THE INFORMATION PROVIDED BY ME ON THIS CLAIM FORM IS TRUE, CORRECT, AND COMPLETE AND THAT THE DATA SUBMITTED IN CONNECTION WITH THIS CLAIM FORM ARE TRUE AND CORRECT COPIES OF WHAT THEY PURPORT TO BE.

Signature: _____ **Printed Name:** _____

Date: ____/____/____

QUESTIONS?

If you have any questions or if you would like to request a paper check, please contact the Settlement Administrator by email at info@[website].com or by mail at: Genetic Screening Test Settlement, c/o Kroll Settlement Administration LLC, P.O. Box 225391, New York, NY 10150-539.