

# Exhibit G

IN RE: AMERICAN MEDICAL COLLECTION AGENCY, INC.

**CUSTOMER DATA SECURITY BREACH LITIGATION**  
**LABCORP SETTLEMENT**

Your claim must be  
submitted online or  
postmarked by:  
**[DEADLINE]**

Civil Action No. 19-md-2904 (JKS)(MAH)(MDL 2904)

**CLAIM FORM****GENERAL INSTRUCTIONS**

**To receive a payment from this Settlement via an electronic payment, you must submit the Claim Form electronically at [www.\\_\\_\\_\\_\\_](http://www._____).com by Month XX, 2026. If you submit your claim through the mail using this Claim Form, payment will be mailed to the address provided below.**

Complete this Claim Form if you are a Settlement Class Member and you wish to receive Settlement benefits.

You are a member of the Settlement Class and eligible to submit a Claim Form if:

You are an individual for whom Labcorp transmitted personal information to Retrieval-Masters Creditor's Bureau, Inc. d/b/a American Medical Collection Agency ("AMCA"), and such information was contained in the computer systems implicated by the cybersecurity incident at AMCA that occurred between approximately August 2018 and March 2019.

The following entities and individuals are excluded from the definitions of "Settlement Class Members" or "Class Members" and are not eligible to receive settlement benefits: Labcorp and its officers and directors; the Judge and/or Magistrate assigned to evaluate the fairness of this settlement; and any other Person found by a court of competent jurisdiction to be guilty under criminal law of initiating, causing, aiding, or abetting the Security Incident or who pleads *nolo contendere* to any such charge.

Settlement Class Members may submit a claim form either for: (1) Out of Pocket Losses from verifiable unreimbursed costs or expenditures that Settlement Class Member actually incurred and that are fairly and reasonably traceable to the AMCA Security Incident up to \$5,000; or (2) Alternative Cash Payment which provides for a \$50 per class members payments, both subject to pro rata increases or decreases dependent on the number of claims filed.

Settlement Class Members may also elect to receive up to two (2) years of medical and healthcare information monitoring services by CyEx Medical Shield Pro.

If you intend to make a claim for Out-of-Pocket Losses, you will need to submit supporting documentation. Out-of-Pocket Losses may include, without limitation, the following:

- unreimbursed costs, expenses, losses or charges incurred as a result of identity theft or identity fraud, medical fraud, or other alleged misuse of Settlement Class Members' personal information;
- professional service costs—such as law firms or credit repair services—related to misuse of Settlement Class Members' personal information;
- miscellaneous expenses incurred related to any Out-Of-Pocket Loss such as notary, fax, postage, copying, mileage, and long-distance telephone charges;
- credit monitoring costs that were incurred on or after August 1, 2018, through the date of the Settlement Class Member's claim submission;
- 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.

Your claim must be submitted online or postmarked by: **[DEADLINE]**

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 CUSTOMER DATA SECURITY BREACH LITIGATION  
 LABCORP SETTLEMENT**

Civil Action No. 19-md-2904 (JKS)(MAH)(MDL 2904)

**CLAIM FORM**

This Claim Form may be submitted electronically via the Settlement Website at [REDACTED] or completed and mailed, including any supporting documentation, to: *American Medical Collection Agency, Inc. Customer Data Security Breach Litigation Labcorp Settlement, Attn: Claims, [ADDRESS]*.

**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**

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.

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

QUESTIONS? VISIT [WWW.\[REDACTED\].COM](http://WWW.[REDACTED].COM) OR CALL TOLL-FREE 1-[REDACTED]

