

# Exhibit C

*In re ApolloMD Data Breach Litigation*  
c/o Kroll Settlement Administration LLC  
P.O. Box XXXX  
New York, NY 10150-XXXX

FIRST CLASS MAIL  
U.S. POSTAGE PAID  
CITY, ST  
PERMIT NO. XXXX

**ELECTRONIC SERVICE REQUESTED**

NOTICE OF CLASS ACTION  
SETTLEMENT

**You are eligible for  
benefits from a class  
action settlement  
regarding the  
ApolloMD  
Data Incident.**

[www.\[website\].com](http://www.[website].com)

<<Refnum Barcode>>

Class Member ID: <<Refnum>>

**Postal Service: Please do not mark or cover**

<<FirstName>> <<LastName>>

<<Address>>

<<Address2>>

<<City>>, <<ST>> <<Zip>>-<<zip4>>

<<Country>>

A Settlement has been reached with ApolloMD Business Services LLC (the “Defendant”) in a class action lawsuit about a data security incident on or around May 22, 2025, in which an unauthorized third party may have accessed and/or acquired files containing the Private Information of patients treated by the Defendant’s affiliated physicians and practices (the “Data Incident”). The Defendant denies any wrongdoing.

**Am I included?** You are receiving this Notice because the Defendant’s records show you are included in the Settlement Class. The Settlement Class consists of all individuals living in the United States who were sent notice that their Private Information may have been impacted by the Data Incident.

**What does the Settlement provide?** If approved by the Court, the Defendant will pay \$4,020,000 to resolve the lawsuit. After deducting court-approved attorneys’ fees and costs and Settlement Administration Costs, the balance will be used to provide Settlement Class Member Benefits. Settlement Class Members may file a Claim Form to receive either (i) a payment of up to \$5,000 for unreimbursed Documented Losses (Cash Payment A) or (ii) an Alternate Cash payment estimated at \$75 (Cash Payment B). Payment amounts may be adjusted based on the number of Valid Claims filed. Settlement Class Members may also choose to receive one (1) year of Medical Data Monitoring.

**How do I get the Settlement Class Member Benefits?** You must file a Claim Form online by 11:59 p.m. ET at [www.\[website\].com](http://www.[website].com) or use the attached Claim Form and mail it to the address on the form postmarked by **Month XX, 2026**. Claim Forms are also available on the Settlement Website or by calling **(XXX) XXX-XXXX**.

**What are my other options?** If you do nothing, you will not receive any Settlement Class Member Benefits, you will remain a member of the Settlement Class, and you will give up your rights to sue the Defendant for the claims resolved by this Settlement. If you do not want any Settlement Class Member Benefits, but you want to keep your right to sue the Defendant for the claims resolved by this Settlement you must exclude yourself from the Settlement Class (called “opting out”). If you do not opt out, you may object to the Settlement and ask the Court for permission to speak at the Final Approval Hearing. The Opt-Out and Objection Deadline is **Month XX, 2026**.

**The Court’s Final Fairness Hearing.** The Court will hold a hearing on **Month XX, 2026** to decide whether to approve the Settlement and up to \$1,340,000 in attorneys’ fees, plus reimbursement of costs. You or your lawyer may attend the hearing at your own expense.

**For more information or to update your address:** Visit [www.\[website\].com](http://www.[website].com) for complete details about the Settlement and instructions on how to act on your rights and options. You may also call **(XXX) XXX-XXXX** for more information.

---

---

---

Place  
Postage  
Here

*In re ApolloMD Data Breach Litigation*  
c/o Kroll Settlement Administration LLC  
P.O. Box XXXX  
New York, NY 10150-XXXX

&lt;&lt;Barcode&gt;&gt;

Class Member ID: &lt;&lt;Refnum&gt;&gt;

**POSTCARD CLAIM FORM**Claim Forms must be postmarked no later than **Month XX, 2026**.**Cash Payment A - Documented Losses:** You MUST submit a Claim Form online or use the full Claim Form available on the Settlement Website to make a claim for documented losses.

Class Member ID: &lt;&lt;refnum&gt;&gt;

&lt;&lt;firstname&gt;&gt; &lt;&lt;mi&gt;&gt; &lt;&lt;lastname&gt;&gt;

&lt;&lt;address1&gt;&gt; &lt;&lt;address2&gt;&gt; &lt;&lt;City&gt;&gt;,

&lt;&lt;State&gt;&gt; &lt;&lt;Zip&gt;&gt;

If different from the preprinted data on the left, please print your correct address information.

Address

City

State

Zip Code

Check the box next to the benefit(s) you are claiming:

You may claim both Cash Payment B - Alternate Cash and Medical Data Monitoring.

- Medical Data Monitoring:** I want to receive one (1) year of Medical Data Monitoring.
- Cash Payment B – Alternate Cash:** I want to receive an alternate cash payment of approximately \$75.\*

\*Final amount to be determined after all valid Claim Forms are submitted.

Select one of the following payment options to receive your Cash Payment:  PayPal  Venmo  Zelle  Check**Required for electronic payment: Mobile Number:** \_\_\_\_\_ **or Email:** \_\_\_\_\_

By signing below, I swear and affirm under the laws of the United States that the information I have supplied in this Claim Form is true and correct to the best of my recollection.

**Signature:****Date (MM/DD/YYYY):**