





I wish to receive payment by check.

If you select check, the check will be provided to the “current” contact information you provided in Section 1.

**Section V – Required Affirmations**

IF SUBMITTED ELECTRONICALLY:

I agree that, by submitting this Claim Form, the information in this Claim Form is true and correct to the best of my knowledge. I understand that my Claim Form may be subject to audit, verification, and Court review. I am aware that I can obtain a copy of the full notice and Settlement Agreement at www.[xxxx].com or by writing the Settlement Administrator at the email address [xxxx]@[xxxx].com or the postal address [Address] [City], [State] [Zip Code]. Checking this box constitutes my electronic signature on the date of its submission.

IF SUBMITTED BY U.S. MAIL:

I agree that, by submitting this Claim Form, the information in this Claim Form is true and correct to the best of my knowledge. I understand that my Claim Form may be subject to audit, verification, and Court review. I am aware that I can obtain a copy of the full notice and Settlement Agreement at www.[xxxx].com or by writing the Settlement Administrator at the email address [xxxx]@[xxxx].com or the postal address [Address] [City], [State] [Zip Code].

Dated: \_\_\_\_\_

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

**SETTLEMENT ADMINISTRATOR ADDRESS (where to send the completed form if submitting by mail): HEALTH IQ TCPA Settlement, c/o \_\_\_\_\_, [Address], [City] [State], [Zip Code].**