## CLAIM FORM

## Section I - Instructions

This Form must be received by the Settlement Administrator no later than [Month] [Day], [Year].

This Claim Form may be submitted in one of three ways:

1. Electronically through www.[xxx].com.
2. Mail to: HEALTH IQ TCPA Settlement, c/o $\qquad$ , [Address], [City] [State], [Zip Code].
3. Email to ADD EMAIL ADDRESS.

To be effective as a Claim under the proposed settlement, this form must be completed, signed, and sent, as outlined above, no later than [Month] [Day], [Year]. If this Form is not postmarked or received by this date, you will remain a member of the Settlement Class but will not receive any payment from the Settlement.

## Section II - Settlement Class Member Information

## Claimant Name (Required):

$\square$

## Claimant Identification Number (Required):

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

* Your claimant identification number was on the notice of the Settlement you received by postal mail. If you do not have your claimant identification number, call or email the Settlement Administrator for assistance at 1-8XX-XXX-XXXX or $[\mathrm{xxx}] @[\mathrm{xxx}] . \mathrm{com}$.


## Current Contact Information

Street Address (Required):

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |

City (Required):
State (Required):
Zip Code (Required)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

## Email (optional):



## Preferred Phone Number:



Your contact information will be used by the Settlement Administrator to contact you, if necessary, about your claim. Provision of your phone number is optional. By providing contact information, you agree that the Settlement Administrator may contact you about your claim.

## Section III - Confirmation of Class Membership

Telephone Number(s) at which you received calls related to HEALTH IQ:
$\square$
$\square$
$\square$
The telephone number identified above belonged to me between May 19, 2018 through December 21, 2021:

Yes $\qquad$ No $\qquad$

## Section IV - Manner of Transmission of Funds

Payment will be by PayPal or direct deposit, unless you request otherwise. You acknowledge that if you do not choose direct deposit or PayPal, you may not receive payment as quickly. Also, the Settlement Administrator is not responsible for Settlement checks that do not arrive and will not reissue checks that are lost or stolen.

## For PayPal

Please provide the email address associated with your PayPal account (if applicable):

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |

For Direct Deposit:
Please provide your relevant routing and account number.
Routing (if applicable):

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |

Account (if applicable):

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- | :--- |

If you do not elect PayPal or Direct Deposit check below:

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:
$\square$ 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: $\qquad$ Signature: $\qquad$
SETTLEMENT ADMINISTRATOR ADDRESS (where to send the completed form if submitting by mail): HEALTHIQ TCPA Settlement, c/o $\qquad$ , [Address], [City] [State], [Zip Code].

