UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

UNITED HEALTHCARE CLASS ACTION LITIGATION

PROOF OF CLAIM FORM

Deadline for Submission: October 5, 2010

You may be entitled to a proportionate share of the $350,000,000 Settlement Fund, if you are a qualified Settlement Class Member and if you fully complete and sign this Claim Form and mail it to the address provided in the following instructions, postmarked by the deadline indicated above. **Please see the Notice for the definition of Settlement Class Member.**

Subscriber. A Subscriber's claim(s) may fall into Group A, B, and/or C, as described below, if your claim(s) meet the requirements. **Please see the Notice for the definition of Subscriber.** You need only submit one Claim Form for each insurance policy ID number (including claims for all family members covered by your policy).

Provider. A Provider's claim(s) may fall into Group D *only*, as described below. **Please see the full Notice for the definition of Provider.**

IF YOU WISH TO BE ELIGIBLE TO RECEIVE THE CASH SETTLEMENT PAYMENT DESCRIBED IN THE NOTICE, YOU MUST COMPLETE AND SIGN THIS CLAIM FORM AND SUBMIT IT BY FIRST CLASS MAIL, POSTMARKED NO LATER THAN OCTOBER 5, 2010, TO:

United HealthCare Class Action Litigation
c/o Berdon Claims Administration LLC
P.O. Box 15000
Jericho, NY 11853-0001

YOUR FAILURE TO SUBMIT THIS CLAIM BY THE DEADLINE MAY CAUSE YOUR CLAIM TO BE REJECTED AND PREVENT YOU FROM RECEIVING ANY MONEY IN CONNECTION WITH THIS SETTLEMENT.

DO NOT MAIL OR DELIVER YOUR CLAIM TO THE COURT OR TO ANY OF THE PARTIES OR THEIR COUNSEL. ANY SUCH CLAIM WILL BE DEEMED NOT TO HAVE BEEN SUBMITTED. SUBMIT YOUR CLAIM *ONLY* TO THE CLAIMS ADMINISTRATOR.

GENERAL INSTRUCTIONS

1. A **Subscriber** who elects to make a Group A claim is not required to provide any documentation in connection with this claim. Please note that you are responsible for your claim being complete.

2. Only **Subscribers** may make claims in Groups A, B, and C. Only **Providers** may make claims in Group D. However, if you are a Provider and **also** meet the definition of a Subscriber (for example, you are a Provider and you are also insured by one of the Defendants), you may be eligible to make a Group D claim (with respect to a claim for which you received an assignment from a Subscriber) **and** to make a claim in Groups A, B and/or C (with respect to your own claims).

3. A **Subscriber** who elects to make a Group B or C claim, and all **Providers** making a Group D claim, are required to provide documentation in connection with their claims. Please note that **you are responsible for your claims being complete and properly documented.**

4. For assistance as a **Subscriber** or **Provider** filing a **Group B, C or D** claim, you may request the Claims Administrator to send you certain information furnished by Defendants (described in Section VI on pages 4-6 of the appended Notice) regarding the Covered Out-of-Network Services or Supplies you either received or provided from January 1, 2002 through May 28, 2010. However, **you must authorize the Claims Administrator to send you this information.** Please complete and sign the **authorization form** available to download from the website at www.berdonclaims.com (preferred), or you may use the authorization form on the bottom of page 15. The **"Notice Number"** requested on the form can be found under the return address on the Notice mailed to you by the Claims Administrator. If you did not receive a mailed Notice from the Claims Administrator, enter "Not Available." Return your completed and signed form to the Claims Administrator by mail, fax or email ***(see the bottom of page 9 for the Claims Administrator's contact information)***.

5. If you are a **Provider** who cannot furnish documentation of an assignment, but you are owed money for providing Covered Out-of-Network Services or Supplies to a Subscriber, you may request information from the Claims Administrator as to whether the Subscriber has made claims for payment from the Settlement Fund by checking the applicable box on page 14 and completing the chart on page 15. *Your request will be processed at the time distribution of the Net Settlement Fund is made.*

6. **Group B, C and D claims only:** Your claims extend from the date **within the Class Period** that you became a Settlement Class **Subscriber** or **Provider** until the Final Order and Judgment Date, which is the date the Court finally approves the Settlement and signs the Final Order. **Your participation as a member of a Defendant's healthcare plan should be counted in whole years, and any portion of a given year should be treated as an entire year.**

7. If you file the claim form *prior* to the Final Order and Judgment Date, but you have additional claims between the date you file the claim form and the Final Order and Judgment Date, you may submit an update to your previously filed claim.

8. If you have any questions concerning your claim, you should **first consult the websites** at www.unitedUCRsettlement.com or www.berdonclaims.com for answers to common, frequently asked questions concerning the Settlement. You may also contact the Claims Administrator toll-free at 800-443-1073, by fax at 516-222-0271, or by email at unitedhealthcare@berdonclaimsllc.com. **You bear all risks of delay and non-delivery of your claim(s).**

9. **For those making Group B, C and/or D claims,** please use a single Claim Form and provide all required information regarding the healthcare services relevant to your claim(s) in the respective charts on pages 11, 12 and 14. If you need additional space, you may download the appropriate chart(s) from the Claims Administrator's website at www.berdonclaims.com, which may be photocopied or replicated in the *same* format. Print your name and insurance policy ID number, social security number, billing tax ID number and/or tax ID number at the top of each numbered chart and attach all additional sheets to your Claim Form with the necessary documentation.

10. Although **Claim Forms *must* be submitted** to the Claims Administrator **by first class mail** ***(see page 8)***, **Subscribers** and **Providers *may* submit copies of any required documentation electronically**. If you prefer to furnish your supporting documentation in an electronic format, such as scanned image files (".bmp") or PDF files, you may do so by copying the files onto a CD. Please make sure that all CDs are clearly labeled. Alternatively, you may submit documentation by email at unitedhealthcare@berdonclaimsllc.com. Please include on all electronic documentation your name and insurance policy ID number, social security number, billing tax ID number and/or tax ID number.

11. **Providers** making claims under Group D **may furnish**, as part of their claim submission, **data from their practice management system and/or accounting records.** It is preferable that your data file be prepared in MS Excel format or tab-delimited text files, and sent to the Claims Administrator on a CD (preferred) or by email at unitedhealthcare@berdonclaimsllc.com.

12. For a list of the Defendants and their subsidiaries and affiliates, please see the Notice.

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THIS CLAIM FORM MUST BE COMPLETED, SIGNED AND SUBMITTED BY FIRST CLASS MAIL, POSTMARKED NO LATER THAN OCTOBER 5, 2010.

REMINDER CHECKLIST

1. Remember to sign and date the above Certification.
2. If you are making claims in Groups B, C, or D, remember to attach your paper or electronic supporting documentation to this Claim Form ***(see above, paragraphs 10 & 11)***.
3. If you want an acknowledgment of receipt of your claim form, please send it by Certified Mail, Return Receipt Requested. **You will bear all risks of delay or non-delivery of your claim.**
4. If your address changes in the future, or if these documents were sent to an old or incorrect address, please send the Claims Administrator **written** notification of your new address. Include your Policy ID Number or Tax ID Number.
5. If you have any questions concerning your claim, please contact the Claims Administrator at:

United HealthCare Class Action Litigation
c/o Berdon Claims Administration LLC
P.O. Box 15000
Jericho, NY 11853-0001
Toll-Free Phone: 800-443-1073
Fax: 516-222-0271
Website: www.berdonclaims.com
Email: unitedhealthcare@berdonclaimsllc.com

PLEASE TYPE OR PRINT

1. Check *one* of the following:

☐ I am a **Subscriber** submitting this Claim Form on my own behalf ***(see page 1 of the appended Notice for a definition of who is a Subscriber under the Settlement).***

_____
Name of Subscriber

_____
Address of Subscriber

_____ _____
Daytime Telephone Number Email Address

_____ _____
Social Security Number Insurance Policy ID Number

Providers: First determine whether a Provider Group Representative, such as your medical group or IPA, intends to file on your behalf.

☐ I am a **Provider** submitting this Claim Form on my own behalf ***(see page 1 of the appended Notice for a definition of who is a Provider under the Settlement).***

_____ _____
Name of Provider Contact Name

_____
Office Address of Provider

_____ _____
Daytime Telephone Number Email Address

_____ _____
Tax ID Number Billing Tax ID Number

☐ I am a **Provider Group Representative** submitting this Claim Form on behalf of one or more Providers employed or associated with the Provider Group. A Provider Group has the right to file claims on behalf of Providers on whose behalf they billed a Defendant for Out-of-Network Services or Supplies covered by the Settlement.

_____ _____
Name of Provider Group Contact Name

_____
Address of Provider Group

_____ _____ _____
Daytime Telephone Number Email Address Billing Tax ID Number

Provider Group Representative: List the name and office address of each Provider for whom you are submitting a claim (*attach additional sheets as necessary*):

Name(s) of Provider(s)	Office Address(es)
_____	_____
_____	_____
_____	_____
_____	_____

☐ I am a **Legal Heir or Representative** of a Subscriber, Provider, or Provider Group Class Member.

Legal Heir or Representative of a Class Member: ***(Attach documentation showing your authority to act on behalf of a Class Member.)***

_____ _____
Name of Legal Heir or Representative Address of Legal Heir or Representative

_____ _____
Daytime Telephone Number Email Address

_____ _____
Name of Person or Entity Represented Address of Person or Entity Represented

_____ **OR** _____ **OR** _____
Social Security Number Tax Identification Number Estate Tax ID Number

DETACH HERE

If you are a Subscriber, proceed to Section 2. If you are a Provider or Provider Group Representative, proceed directly to Section 5.

2. Group A: Simplified Claim Form for Subscribers

☐ I am a Subscriber and I wish to make a Group A claim.

State the number of years (from 1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan which provided coverage for Out-of-Network Services or Supplies **(any portion of a given year should be treated as a whole year). Number of membership years: _____**.

Only *Subscribers* Are Eligible to Make a Group A Claim

As a Group A claimant, you need *only* to provide the number of years **you** have been a member of a Defendant's healthcare plan that provided coverage for Out-of-Network medical services or supplies, and **you need not furnish any further documentation.**

However, if you elect to be a Group A claimant you may **not** elect to be included in Group B or C even if you satisfy the conditions for inclusion in such group(s). You must certify to the accuracy of this information ***(see Section 6, below)***, and the Claims Administrator may review data to determine the accuracy of the information you provide.

Please ***review the Plan of Allocation included in Section VI, pages 4-6, of the appended Notice*** for further information on the Recognized Losses allocated for Groups B and C before deciding whether it may be to your advantage to make a Group B and/or C claim rather than a Group A claim.

After reading the instructions above, Group A claimants should proceed directly to Section 6 of this Claim Form. You do not need to complete any other sections.

Group B and Group C Subscribers and Group D Providers: Use a single Claim Form to list information in the respective charts below regarding all of the healthcare services relevant to your claim(s). If you need additional space, download the appropriate chart(s) from the Claims Administrator's website at www.berdonclaims.com. The charts may be photocopied or replicated in the same format. Print your name and insurance policy ID number, social security number or tax ID number at the top of each numbered chart and attach all additional sheets to your Claim Form with the necessary documentation.

DETACH HERE

3. Group B: Subscribers Who Paid Out-of-Pocket

☐ I am a Subscriber and I wish to make a Group B claim.

☐ I received an Adjusted Bill(s) from my Out-of-Network Provider(s).

For information concerning eligibility to make a Group B claim, see Section VI, page 5, of the appended Notice.

3(a) State the number of years (from 1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan which provided coverage for Out-of-Network Services or Supplies **(any portion of a given year should be treated as a whole year)**: _____ *(must be completed).*

3(b) For **each** Covered OON Service or Supply received, please provide the following information (*must be documented*):

Date of Service or Purchase of Supply	Name of Provider	Name of Patient	Original Bill Amount	Allowed Amount	Adjusted Bill Date	Adjusted Bill Amount	Paid Portion of Adjusted Bill
						Total:	$

(Additional chart available on Claims Administrator's website at www.berdonclaims.com)

Only *Subscribers* Are Eligible to Make a Group B Claim

You are eligible to participate as a Group B claimant *only* if you paid out-of-pocket to your Out-of-Network Provider an amount above the Allowed Amount for Covered Out-of-Network Services or Supplies, and attach to this Claim Form paper or electronic copies of the required documentation ***(for electronic documentation, see page 9, paragraph 10)***.

If you paid a portion of the amount to your Out-of-Network Provider but did not pay the remainder, you may have both a Group B claim (for the amount you paid), and a Group C claim (for the amount you did not pay).

Attach to this Claim Form paper or electronic copies of documentation for *each* of your out-of-pocket payment(s) to your Out-of-Network Provider(s), including:

- copies of cancelled checks; ***or***
- receipts for cash payments; ***or***
- invoices from your Out-of-Network Provider(s) indicating your payment(s); ***or***
- internal accounting records from your Out-of-Network Provider (such as paid account records) reflecting your payment(s); ***and***
- Explanation(s) of Benefits ("EOBs") or other documentation demonstrating that your Provider(s) was/were Out-of-Network and rendered Covered Out-of-Network Services or Supplies.

4. Group C: Adjusted Bill Claims Not Fully Paid by *Subscribers*

☐ I am a Subscriber and I wish to make a Group C claim.

☐ I received an Adjusted Bill(s) from my Out-of-Network Provider(s).

For information concerning eligibility to make a Group C claim, see Section VI, page 5, of the appended Notice.

4(a) State the number of years (from 1994 through 2009, inclusive) that you have been a member of a Defendant's healthcare plan which provided coverage for Out-of-Network Services or Supplies **(any portion of a given year should be treated as a whole year)**: _____ *(must be completed).*

4(b) For **each** Covered OON Service or Supply received, please provide the following information (*must be documented*):

Date of Service or Purchase of Supply	Name of Provider	Name of Patient	Original Bill Amount	Allowed Amount	Adjusted Bill Date	Adjusted Bill Amount	Unpaid Portion of Adjusted Bill	Percent of Recognized Loss Claimed: 50%/70%/90%
						Total:	$	

(Additional chart available on Claims Administrator's website at www.berdonclaims.com)

Only *Subscribers* Are Eligible to Make a Group C Claim

You are eligible to participate as a Group C claimant ***only*** if you received an Adjusted Bill from an Out-of-Network Provider for Covered Out-of-Network Services or Supplies, and did **not** pay the Adjusted Bill in whole or in part. (An Adjusted Bill means a bill sent to you by your Out-of-Network Provider reflecting the unpaid portion of the amount the Provider initially billed to a Defendant) and attach to this Claim Form paper or electronic copies of the required documentation ***(for electronic documentation, see page 9, paragraph 10)***.

If your Out-of-Network Provider did **not** initially bill a Defendant but sent you the initial bill, the Adjusted Bill amount is the amount of the initial bill for which you were not reimbursed by a Defendant and you did not pay to the Provider.

If you paid a portion of the amount to your Out-of-Network Provider but did not pay the remainder, you may have both a Group B claim (for the amount you paid), and a Group C claim (for the amount you did not pay).

Attach to this Claim Form paper or electronic copies of documentation proving your receipt of an Adjusted Bill and that the amount you did not pay was for Covered Out-Of-Network Services or Supplies rendered by a Provider who was Out-of-Network, including:

- a copy of *each* Adjusted Bill; ***or***
- evidence from your Out-of-Network Provider's records that each Adjusted Bill was sent to you; **and**
- Explanation(s) of Benefits ("EOBs") or other documentation demonstrating that your Provider(s) was/were Out-of-Network and rendered Covered Out-of-Network Services or Supplies.

DETACH HERE

Adjusted Bill Submitted to Collection Agency

You may have a higher Recognized Loss under the Plan of Allocation if you also furnish evidence that the Adjusted Bill was submitted to a collection agency, reported to a credit agency, or that you entered into a payment plan with your Out-of-Network Provider. ***(Review the Plan of Allocation included in Section VI, page 5, of the appended Notice for more information.)***

Attach to this Claim Form paper or electronic copies of documentation, including:

- a written notice from a collection agency; ***or***
- evidence of telephone contact with a collection agency (complete the information below); ***or***
- a printout of your credit report showing that the debt to your Out-of-Network Provider was reported to a credit agency; ***or***
- an agreement with your Out-of-Network Provider to enter into a payment plan with you.

Telephone Contact(s) From Collection Agency(ies):

Date(s) of Contact(s)	Name(s) of Agency(ies)

The amount of your Recognized Loss also depends on the date(s) of the above documents, as well as the date(s) you received an Adjusted Bill. ***(Review the Plan of Allocation included in Section VI, page 5, of the appended Notice for additional information.)***

If you are a Group B or Group C Subscriber, go directly to Section 6.

5. Group D: *Provider* Claims

☐ I am a Provider (or Provider Group Representative or Legal Representative) and I wish to make a claim. I received an assignment from a Subscriber.

5(a) Simplified Claim for Providers

You may choose to file your claim based **solely** on the information furnished to the Claims Administrator by Defendants regarding the Covered Out-of-Network services or Supplies you provided to Subscribers from January 1, 2002 through May 28, 2010. **If you wish to review this information for accuracy prior to filing a Simplified Group D claim, you must submit an authorization form for its release** ***(for instructions, see page 8, paragraph 4)***. You will be eligible to receive 50% of the Recognized Loss (the difference between what you billed a Defendant and the amount the Defendant and/or the Subscriber paid you), limited to the period available for the report. Indicate your intention to file a Simplified claim, by checking the box below:

☐ I choose to file a Simplified Group D claim.

5(b) Claim for Providers Seeking Increased Damages

To recover for claims in addition to those included on the Claims Administrator's report (1/1/02 through 5/28/10), or to have a higher Recognized Loss, you must complete the chart at the end of this section and attach to this Claim Form paper or electronic copies of the required documentation ***(for electronic documentation, see page 9, paragraphs 10 and 11). IMPORTANT: Claims added for services or supplies provided before 1/1/02 or after 5/28/10 require complete supporting documentation.***

To be eligible to have 50% of the Recognized Loss (the difference between what you billed a Defendant and the amount the Defendant and/or the Subscriber paid you), ***attach paper or electronic copies of the following:***

- a claim for OON Services or Supplies furnished during the Class Period and submitted to a Defendant; ***or***
- a cancelled check from a Defendant for services furnished during the Class Period, ***or***
- an Explanation of Benefits/Explanation of Payment/Remittance Advice from a Defendant indicating that payment was made to you for services furnished during the class period; ***or***
- evidence from your practice management system records or internal accounting records (such as a print-out or electronic version of your accounts receivable or paid account records) that reflects that you sent a claim form addressed to a Defendant pursuant to an assignment for services furnished during the class period, or received payment from a Defendant for such services; ***and***
- evidence of payment (if any) from a Subscriber for services furnished during the Settlement Class Period.

To be eligible to have 70% of the Recognized Loss, *attach paper or electronic copies of the following*:

- the documentation listed in the section above; ***and***
- the Adjusted Bill sent to a Subscriber on or after January 1, 2002; ***or***
- evidence from your practice management system records or internal accounting records that reflects that you sent an Adjusted Bill to the patient on or after January 1, 2002.

DETACH HERE

To be eligible to have 90% of the Recognized Loss, ***attach paper or electronic copies of the following:***

- the documentation listed in the first section above; ***and***
- correspondence with or notice to a collection agency or credit agency; ***or***
- a payment plan you entered into with a Subscriber; ***or***
- evidence from your practice management system records or internal accounting records that reflects that you submitted the Adjusted Bill to a collection agency, reported the Adjusted Bill to a credit agency or entered into a payment plan with the patient.

5(c) For **each** Covered OON Service or Supply provided, please complete the following information:

Date of Service or Purchase of Supply	Name of Patient	Patient's Policy ID Number	Provider's UHC Claim ID Number	Original Bill Amount	Allowed Amount	Adjusted Bill Date	Adjusted Bill Amount	Amount Paid*	Choose % of Recognized Loss Claimed: 50%/70%/90%

(Additional chart available on Claims Administrator's website at www.berdonclaims.com)
***Excluding co-payment and/or deductible.**

Only *Providers* (or Provider Group Representatives) Are Eligible to Make a Group D Claim

You are eligible to participate as a Group D claimant **only** if you (1) received an assignment from a Subscriber, (2) submitted a claim for reimbursement to a Defendant for Covered Out-of-Network Services or Supplies based on the assignment, and the claim was processed or reimbursed by a Defendant using an Ingenix Database or one of the Seven OON Reimbursement Policies, and (3) have not transferred, sold, or assigned the claim. You must furnish documentation that you received an assignment from a Subscriber, and certify in Section 6 that you received such an assignment. ***(See page 1 of the appended Notice for a list of the Seven OON Reimbursement Policies.)***

You may have a higher Recognized Loss if you sent an Adjusted Bill to a Subscriber and the Subscriber did not pay some of the Adjusted Bill amount. ***(Review the Plan of Allocation in Section VI, page 5, of the appended Notice for additional information.)*** Valid documentation of an Adjusted Bill includes a copy of *each* Adjusted Bill you sent, or documentation from your practice management software records or internal accounting records (such as a print out or electronic version of your accounts receivable or paid account records) that *each* Adjusted Bill was sent. Attach copies to this Claim Form.

You may have a higher Recognized Loss if you *also* furnish documentation that the Adjusted Bill was submitted to a collection agency, reported to a credit agency, or that you entered into a payment plan with a Subscriber. ***(Review the Plan of Allocation included in Section VI, page 5, of the appended Notice for additional information)***. Valid documentation includes a written notice to a collection agency, a notice or other correspondence to a credit agency reporting the debt, or an agreement with a Subscriber to enter into a payment plan (or evidence from your practice management software records). Attach to this Claim Form paper or electronic copies of the required documentation ***(for electronic documentation, see page 9, paragraphs 10 and 11).***

The amount of your Recognized Loss also depends on the date(s) of the above documents as well as the date(s) you sent an Adjusted Bill, if at all. ***(Review the Plan of Allocation included in Section VI, page 5, of the appended Notice for additional information.)***

To receive payment from the Settlement Fund you must release the Subscriber from further liability relating to the specific claim you make.

Providers *who cannot furnish documentation* and certify in Section 6 that they received an assignment (and, therefore, who cannot make a Group D claim) *may nonetheless request information* from the Claims Administrator as to whether a Subscriber who owes them money for Covered Out-of-Network Services or Supplies has made a claim for payment from the Net Settlement Fund. This request may be made by checking the box below and providing the Subscribers' names and amounts of debt to the Provider in the chart on page 15:

☐ I am a Provider (or Provider Group Representative or Legal Representative) and I wish to request information as to whether the Subscriber(s) listed in the chart on page 15 made a claim for payment from the Net Settlement Fund.

DETACH HERE

Name of Subscriber	Subscriber's Policy ID Number	Amount of Debt to Provider
	Total:	$

(Additional chart available on Claims Administrator's website at www.berdonclaims.com)

A Provider making a request for this information *must furnish documentation to demonstrate that the Provider is owed money by a Subscriber* for Covered Out-of-Network Services or Supplies.

6. Certification

I hereby certify under penalty of perjury that, to the best of my knowledge, the information above and all supporting documentation attached are true and correct.

_____
Signature of Subscriber, Provider, Provider Group, or Legal Heir or Representative

_____
Print Your Name Here

Date: _____

_____
Capacity of Legal Heir or Representative (Administrator, Executor, Attorney, Custodian, Parent, or Guardian)

THIS CLAIM FORM MUST BE COMPLETED, SIGNED AND SUBMITTED BY FIRST CLASS MAIL, POSTMARKED NO LATER THAN OCTOBER 5, 2010. ***(SEE REMINDER CHECKLIST ON PAGE 9.)***

DETACH HERE

CLAIMS INFORMATION REQUEST AUTHORIZATION FORM

☐ I am a Class Member in the United HealthCare Class Action Litigation, and I authorize the Defendants to send the Claims Administrator, and the Claims Administrator to send me a copy of the information furnished by Defendants regarding the Covered Out-of-Network Services or Supplies that I received/provided from January 1, 2002 through May 28, 2010 to assist me in filing a Group B, C or D claim.

Name: _____

Address: _____

_____

Subscribers Only

Notice Number:
(see page 8, paragraph 4) _____

Insurance Policy ID No.: _____

Social Security Number: _____

Providers Only

Notice Number:
(see page 8, paragraph 4) _____

Billing Tax ID No.: _____

Tax ID No.: _____

I certify under penalty of perjury that to the best of my knowledge, the information above is true and correct. This authorization form is executed this _____ day of _____ 2010 in _____ (City), _____ (State).

_____
Signature

_____
Print your name

(This Authorization Form should be completed, signed and returned to the Claims Administrator only if you wish to receive claims information to assist you in filing a Group B, C or D claim. For detailed instructions, see page 8, paragraph 4.)

United HealthCare Class Action Litigation
c/o Berdon Claims Administration LLC
P.O. Box 15000
Jericho, NY 11853-0001

IMPORTANT LEGAL INFORMATION

PRESORTED
FIRST-CLASS MAIL
U.S. POSTAGE PAID
PEARL PRESSMAN LIBERTY
COMMUNICATIONS GROUP

UNITED HEALTHCARE