

You may print this Claim Form and complete it by hand, or you may complete this fillable PDF Claim Form using your computer. After completing it, save it to your computer. You can then visit the website at [www.BeckettPrivacyClassAction.com](http://www.BeckettPrivacyClassAction.com) and click "File a Claim" to upload it. In order to upload your claim, you will need the Personal Claimant # and Confirmation Code that was printed at the top of the Notice you received in the mail.

### **CLAIM FORM INSTRUCTIONS**

**IMPORTANT -- All Settlement Class Members will automatically receive a minimum Base Payment of either: (1) \$75 to all Settlement Class Members whose Protected Health Information was allegedly disclosed improperly by Aetna to Aetna's legal counsel and a settlement administrator; or (2) \$500 (inclusive of the \$75 dollar payment above) to all Settlement Class Members who were sent the Benefit Notice, whichever is applicable. The "Benefit Notice" was the notice that was sent by a settlement administrator to certain Settlement Class Members to inform Aetna members of their ability to fill prescriptions for certain medications through mail order or retail pharmacy, as required by the settlement of legal claims that had been filed against certain Aetna-related entities or affiliates in *Doe v. Aetna, Inc.*, No. 14-cv-2986 (S.D. Cal.).**

This Claim Form is solely for Class Members who were sent the Benefit Notice and claim to have suffered financial harm (meaning non-reimbursed out-of-pocket expenses) or non-financial harm. If you do not claim to have suffered financial harm or non-financial harm as a result of the mailing of the Benefit Notice, then you should not fill out this Claim Form.

**If you decide to fill out this Claim Form, please answer all questions honestly and accurately. You are swearing under penalty of perjury that your statements below are true and correct as if you were testifying in court.**

Part I below is your Claimant Information. Part II below covers the reimbursement of non-reimbursed out-of-pocket expenses that you claim to have incurred as a result of being sent the Benefit Notice. Part III below covers non-financial harms that you claim to have suffered as a result of being sent the Benefit Notice. Claimants can seek a monetary settlement award pursuant to this Settlement under either Part II or Part III or both.

To complete this Claim Form, you must:

- (a) completely fill out Part I -- Claimant Information;
- (b) completely fill out either or both of Part II -- Financial Harm, and/or Part III -- Non-Financial Harm, as applicable to you;
- (c) personally sign the Certification and Declaration in Part IV;
- (d) attach all documentation of your alleged harm as requested below; and
- (e) return your completed Claim Form and any requested documentation to the Settlement Administrator.

**YOU MUST SUBMIT YOUR COMPLETED CLAIM FORM BY SEPTEMBER 29, 2018 IN ORDER FOR IT TO BE CONSIDERED TIMELY.**

You may fill out this Claim Form in hard copy or you may download and fill out the electronic Claim Form located at [www.BeckettPrivacyClassAction.com](http://www.BeckettPrivacyClassAction.com). The electronic Claim Form can be uploaded using the HIPAA-compliant portal also located on the website. If you fill out the Claim Form in hard copy, you may return it by uploading it using the HIPAA-compliant portal at [www.BeckettPrivacyClassAction.com](http://www.BeckettPrivacyClassAction.com). You may mail your Claim Form by using the self-addressed stamped envelope enclosed with the notice you received in the mail or, if you did not receive a notice in the mail, you may mail your Claim Form to:

Settlement Administrator  
PO Box 15860  
Philadelphia, PA 19103

If you have any questions about this Claim Form, please call the Settlement Administrator toll-free at 877-416-7259 or contact the Settlement Administrator using the Contact Us form located at [www.BeckettPrivacyClassAction.com](http://www.BeckettPrivacyClassAction.com). For additional information about the Settlement, please visit [www.BeckettPrivacyClassAction.com](http://www.BeckettPrivacyClassAction.com).

<b>Your claim must be postmarked by: September 29, 2018</b>	<b>Beckett v. Aetna Inc. Settlement <u>Claim Form</u></b>	<b>BVA</b>
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**PART I -- CLAIMANT INFORMATION**

**Note -- All information you provide on this Claim Form will be kept strictly confidential by the Settlement Administrator and will be destroyed by the Settlement Administrator after the distribution of the settlement proceeds.**

**Name of Claimant:**

**Personal Claimant #:**

(located on the first page of the Notice of Settlement you received with this Claim Form)

**Street:**

**City:**  **State:**  **Zip:**

**Phone:**  **Email:**

**Note -- It is your responsibility to let the Settlement Administrator know if your mailing address changes at any time before you receive a Settlement Payment or if you want future mail sent to a different mailing address.**

**PART II -- FINANCIAL HARM**

Please list and provide an itemization below of all non-reimbursed out-of-pocket expenses you claim were caused by the mailing of the Benefit Notice for which you are seeking reimbursement pursuant to this Settlement, and for each expense listed, **you must attach and return to the Settlement Administrator the corresponding receipt, invoice, credit card statement, medical record, insurance record, copy of returned check, or other reasonable form of evidence documenting that you made each payment listed below.** If you need more room, please continue the list on a separate sheet of paper and return it to the Settlement Administrator along with this Claim Form and the required documentation.

Specific description of each non-reimbursed out-of-pocket expense for which you are requesting reimbursement	Date of the expense	Dollar amount of the specific expense
1.)		
2.)		
3.)		
4.)		
5.)		
<b>Total Amount Claimed:</b>		

**PART III – NON-FINANCIAL HARM**

If you claim to have suffered non-financial harm as a result of the mailing of the Benefit Notice, you are eligible to receive a monetary award based upon your answers to the questions below. Please carefully review and answer each question below in detail. If the question does not apply to you, please leave the answer blank or write “not applicable.” Each answer you provide below is submitted under penalty of perjury as if you were testifying in court.

<b>ANSWER EACH QUESTION BELOW IN DETAIL OR LEAVE IT BLANK IF IT IS NOT APPLICABLE</b>
<p>1. If someone other than you received your mail the day the Benefit Notice arrived, please explain in detail the circumstances and identify the person(s) that received your Benefit Notice.</p>
<p>2. If your Benefit Notice was left in an area visible to others, please explain in detail the circumstances and state where the Benefit Notice was left.</p>
<p>3. If your Benefit Notice was delivered to a residence or post office box that was not yours, please explain in detail the circumstances including how you came to know of this.</p>

4. If as a result of the Benefit Notice, one or more people learned that you were taking the prescribed medication, please explain in detail the circumstances including by identifying the people who learned that you were taking the prescribed medication.
5. If as a result of the Benefit Notice, you felt forced to explain to someone for the first time about your reason(s) for taking the prescribed medication (including, for example, disclosing your sexual orientation, sexual practices, or medical condition), please explain in detail the circumstances including by identifying the person(s) that you felt forced to talk with, and their relationship to you.
6. If as a result of the Benefit Notice, your medical condition, sexual orientation, sexual practices, and/or reason(s) for taking the prescribed medication has become the subject of gossip in your community, please explain in detail the circumstances.
7. If as a result of the Benefit Notice, your medical condition, sexual orientation, sexual practices, and/or reason(s) for taking the prescribed medication has become known to your employer in a way that was not caused by you, or has affected your employment, please explain in detail the circumstances.
8. If as a result of the Benefit Notice, you have a need for medical or mental health treatment, including counseling, but have not yet received it, please explain in detail the circumstances and why you believe you require medical or mental health treatment.
9. If as a result of the Benefit Notice, you have been treated differently, harassed and/or shunned by family, friends, roommates, neighbors, landlords, or others, please explain in detail the circumstances and identify how you have been treated differently, harassed and/or shunned, and by whom.
10. If as a result of the Benefit Notice, one or more of your important relationships has been damaged, please explain in detail the circumstances and identify the relationship(s) that has been damaged, and how.
11. If as a result of the Benefit Notice, you feel the need to change residences but have not yet done so, please explain in detail the circumstances and identify why you feel the need to change residences and why you have not yet done so.

<p>12. If as a result of the Benefit Notice, you or your dependents have sought and received medical or mental health treatment, including counseling, please explain in detail the circumstances, state how many counseling sessions or visits have occurred, <u>and provide some form of evidence, including by attaching and returning to the Settlement Administrator a doctor's note, insurance record, receipt, invoice, credit card statement, bank statement, copy of returned check, or any other reasonable form of evidence evidencing the visit(s).</u></p>
<p>13. If as a result of the Benefit Notice, you have experienced repeated episodes of any of the following: trouble sleeping, anxiety, extreme stress, extreme anger, panic attacks, loss of appetite, loss of trust, and/or depression, please explain in detail the circumstances.</p>
<p>14. If as a result of the Benefit Notice, someone in your household has moved out because they no longer wanted to live with you as a result of finding out your reason(s) for taking the prescribed medications, please explain in detail the circumstances, including by identifying the person who previously lived with you and their relationship with you.</p>
<p>15. If as a result of the Benefit Notice, you have been physically harmed or threatened with serious violence or threat of bodily injury, please explain in detail the circumstances, including by identifying the person(s) who harmed or threatened you with serious violence, and describing what occurred.</p>
<p>16. If as a result of the Benefit Notice, you had to change residences, please explain in detail the circumstances, and provide your old and new address, the reason(s) you moved, <u>and provide some form of evidence of your move.</u></p>
<p>17. If as a result of the Benefit Notice, you suffered any additional non-financial harm that is not covered by any of the above questions, please explain in detail the circumstances.</p>

**PART IV – CERTIFICATION AND DECLARATION**

I hereby declare under penalty of perjury pursuant to 28 U.S.C. § 1746 and the laws of the United States of America that all of the information I have provided above is true and correct.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME

**PART V -- REMINDER CHECKLIST BEFORE YOU SUBMIT THIS CLAIM FORM**

1. Make sure that you fully completed Part I -- Claimant Information.
2. Make sure that you fully completed either or both of Part II and Part III as applicable to your personal situation.
3. Make sure that you signed the Certification and Declaration in Part IV.
4. Make sure that when you return your Claim Form that you include a copy of all required documentation requested above.
5. Make sure that you retain a copy of this Claim Form and your supporting documentation for your records.