**CLAIM FORM**

**FOR OFFICIAL USE ONLY**

**To make a claim for a Settlement payment, complete and sign this form and mail it along with the required documentation to the address listed below, postmarked no later than June 14, 2010:**

* 1 2 3 4 5 6 7 8 9 * - 000
NAME
ADDRESS
CITY STATE ZIPCODE

## A. CONTACT INFORMATION

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: ( __ __ __ ) __ __ __ - __ __ __ __

## B. CLAIM INFORMATION

**To receive a cash payment of up to one hundred percent (100%) of the PPO discounts taken by or on behalf of CNA, supply the following information. The payment is subject to audit and challenge by CNA, and to a pro rata reduction based upon the aggregate payment limit described in paragraph 6.4 of the Settlement Agreement.**

- Tax Identification Number (TIN) or
  Social Security Number or Federal Employer Identification Number: _____

***AND***

- Itemization of all applicable charges for which PPO reductions or discounts purportedly were taken. Such itemization must be accomplished by submitting 1) a copy of the explanation of review(s) ("EOR") that itemizes charges, discounts or reductions, and the reasons therefore; or 2) any other materials received from CNA or the bill review company that itemize charges, discounts or reductions, and the reasons therefor, sufficient to ascertain the specific charges billed, their dates, the patient for whom the services were provided, and the specific PPO reductions or discounts taken by or on behalf of CNA.

I am enclosing or attaching documentation showing $ _____ . __ in PPO reductions or discounts taken by or on behalf of CNA from February 15, 1995 through February 26, 2010.

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that he verily believes the same to be true.

Signature: _____

**Mail a copy of this Claim Form and any required documentation, postmarked no later than June 14, 2010, to:**

**Fischer v. CNA PPO Class Action**
**P.O. Box 2297**
**Faribault MN 55021-2432**

* C N A S *



* 1 - 1 *