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CLAIM FORM FOR TRINITY HEALTH DATA SECURITY INCIDENT SETTLEMENT

Doe, et al. v. Trinity Health Corporation, et al.
Case No. 21CECG01454 (Fresno Superior Court)

USE THIS FORM TO MAKE A CLAIM FOR A *PRO-RATA* CASH PAYMENT AND/OR REIMBURSEMENT OF DOCUMENTED OUT-OF-POCKET LOSSES

The DEADLINE to submit this Claim Form is: Month DD, YYYY [INSERT deadline date]

To receive a settlement benefit from this settlement via an electronic payment, you must submit the Claim Form below electronically at www.TrinityHealthSettlement.com by <<Claims Deadline>>.

I. GENERAL INSTRUCTIONS

If you are a California resident to whom Defendant Trinity Health Corporation ("Trinity Health") sent a direct mail notice of a Data Security Incident that involved the Accellion File Transfer Appliance, you are a Settlement Class Member and entitled to participate in the settlement. Complete information about the Settlement and its benefits are available on the Settlement Website at **www.TrinityHealthSettlement.com.** If you received a Short-Form Notice postcard about this class action Settlement by mail addressed to you, then the Settlement Administrator has already determined that you are on Trinity Health's list of Settlement Class Members. If you are not sure whether you are a Settlement Class Member, you may contact the Settlement Administrator via U.S. Mail at [**INSERT Settlement Administrator Address**] or by emailing **info@TrinityHealthSettlement.com** or calling **(800) ###-####** [**INSERT Settlement Administrator 800 number**]. Only Settlement Class Members identified on Trinity Health's list may submit a Claim Form.

This Claim Form may be completed and submitted online at **www.TrinityHealthSettlement.com** or completed and mailed to the address below. Please type or legibly print all requested information, in blue or black ink. Mail your completed Claim Form, including any supporting documentation, to: [**INSERT Settlement Administrator Address**].

II. PAYMENT SELECTION

If you would like to elect to receive your settlement benefit through electronic transfer, please visit the Settlement Website and timely file your Claim Form. The Settlement Website includes a step-by-step guide for you to complete the electronic payment option.

III. CLAIMANT INFORMATION

The Settlement Administrator will use this information for all communications regarding this Claim Form and the Settlement.

First Name | MI | Last Name

Alternative Name(s)

Mailing Address, Line 1

Mailing Address, Line 2

City | State | Zip Code

Telephone Number (Primary) - - | Telephone Number (Secondary) - -

Email Address

[EXHIBIT 3]
Questions? Go to www.TrinityHealthSettlement.com or call (800) ###-####.

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Date of Birth (MM/DD/YYYY)

Claim Number Provided on Short-Form Notice (if known)

IV. *PRO-RATA* CASH PAYMENT

If you wish to receive a *Pro-Rata* Cash Payment, simply fill out Section II, above, and submit or mail this Claim Form to the Settlement Administrator no later than **Month DD, YYYY [INSERT deadline date]**. The amount of the *Pro-Rata* Cash Payment will depend on how many eligible people submit Claim Forms.

Cash Payments will be made by check sent by U.S. Mail. If you prefer to receive a Cash Payment via electronic payment, provide your email address associated with your PayPal, Venmo, or Zelle account below and select your preferred payment method below:

Email Address

Select one: ☐ PayPal, ☐ Venmo, ☐ Zelle

V. REIMBURSEMENT FOR DOCUMENTED OUT-OF-POCKET LOSSES

In addition to a Pro-Rata Cash Payment, you are eligible to seek reimbursement for up to $1,000.00 for your documented, out-of-pocket losses or expenditures that you incurred that are fairly traceable to the Data Security Incident ("Documented Out-of-Pocket Losses"). Documented Out-of-Pocket Losses include, for example: losses incurred as a result of documented identity theft or fraud, which are attributable to the Data Security Incident that occurred on or about January 20, 2021, card cancellation or replacement fees, credit-related costs related to purchasing credit reports, credit monitoring or identity theft protection, costs to place a freeze or alert on credit reports, costs to replace social security number, and/or late fees, declined payment fees, overdraft fees, returned check fees, customer service fees attributable to documented identity theft or fraud. Your attorneys' fees and costs are not eligible for reimbursement as Documented Out-of-Pocket Losses.

To make a valid claim for Documented Out-of-Pocket Losses, you must fill out Section II above and additionally (i) provide the requested information below or provide the requested information below on a separate sheet submitted with this Claim Form; (ii) sign the attestation at the end of this Claim Form (Section V); and (iii) include Reasonable Documentation supporting each claimed expense along with this Claim Form. Documented Out-of-Pocket Losses fairly traceable to the Data Security Incident will be determined by the Settlement Administrator. In order to be deemed fairly traceable to the Data Security Incident, the Documented Out-of-Pocket Losses are required have occurred between **January 20, 2021** and **Month DD, YYYY [INSERT Claims Deadline date]**, and for which you have not already received reimbursed by a third party. Documented Out-of-Pocket Losses for credit monitoring or identity theft protection services are additionally required are required have occurred between **July 1, 2022** (which is one year after expiration of Trinity Health's offer of a complimentary one year enrollment in Kroll Credit Monitoring, Fraud Consultation, and Identity Theft Restoration services made to Settlement Class Members in Trinity Health's written notification of the Data Security Incident) and **Month DD, YYYY [INSERT Claims Deadline date]**.

Expense Type (Check all that apply)	**Date of Loss** (Approximate)	**Amount of Loss**	**Description of Reasonable Documentation** (What you are attaching and why)
☐ Losses from identity theft or fraud	☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)	$☐☐,☐☐☐.☐☐	*Examples: Copy of Police Report; Receipt for Copy of Police Report; Account statement with unauthorized charges highlighted; Correspondence from financial institution declining to reimburse you for fraudulent charges.* Description of what you are attaching:
☐ Fees or costs incurred in connection with identity theft or fraud	☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)	$☐☐,☐☐☐.☐☐	*Examples: Receipt for hiring service to assist you in addressing identity theft; Accountant bill for re-filing tax return.* Description of what you are attaching:
☐ Lost interest or other damages resulting from delayed state or federal tax refund resulting from fraudulent tax return	☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)	$☐☐,☐☐☐.☐☐	*Examples: Letter from IRS or state taxing authority about tax fraud in your name; Documents reflecting length of time you waited to receive your tax refund and the amount thereof.* Description of what you are attaching:
☐ Credit freeze	☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)	$☐☐,☐☐☐.☐☐	*Examples: Notices or account statements reflecting payment for a credit freeze.* Description of what you are attaching:
☐ Credit monitoring that was purchased after July 1, 2022	☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)	$☐☐,☐☐☐.☐☐	*Examples: Receipts or account statements reflecting purchases made for identity theft protection and/or credit monitoring services.* Description of what you are attaching:

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Expense Type (Check all that apply)	**Date of Loss** (Approximate)	**Amount of Loss**	**Description of Reasonable Documentation** (What you are attaching and why)
☐ Miscellaneous expenses such as late fees, declined payment fees, overdraft fees, returned check fees, customer service fees, notary, fax, postage, copying, mileage, and/or long-distance telephone charges attributable to documented identity theft or fraud	/ / (mm/dd/yyyy)	$, .	*Example: Receipts or account statements reflecting late fees, declined payment fees, overdraft fees, returned check fees, customer service fees, phone bills, gas receipts, postage receipts; detailed list of locations to which you traveled (such as police station or IRS office), indication of why you traveled there (i.e. police report or letter from IRS regarding falsified tax return) and number of miles you traveled, attributable to documented identity theft or fraud.* Description of what you are attaching:
☐ Other (provide detailed description)	/ / (mm/dd/yyyy)	$, .	Description of what you are attaching:

VI. ATTESTATION
(REQUIRED FOR A CLAIM FOR DOCUMENTED OUT-OF-POCKET LOSSES)

I, _____ [Name], declare that I incurred and/or expended the Documented Out-of-Pocket Losses claimed above as a result of the Data Security Incident.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed on _____, in _____, _____.
[Date] [City] [State]

_____
[Signature]

[EXHIBIT 3]
Questions? Go to www.TrinityHealthSettlement.com or call (800) ###-####.