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Nemeth v. Columbia University Health Care, Inc.

Supreme Court of the State of New York, County of New York
Case No. 655570/2024

CLAIM FORM

This Claim Form should be filled out online or submitted by mail if you are a Settlement Class Member and received a notification from **Columbia University Health Care, Inc. ("Columbia" or "Defendant")**, that your Private Information was or may have been impacted in the alleged Data Incident that is alleged to have occurred between **September 11, 2023, and March 7, 2024**.

Settlement Class Members should complete this Claim form if they wish to claim two years of CyEx Medical Shield Complete medical monitoring, reimbursement for compensation for Documented Losses, and/or a Pro Rata Cash Payment. You may get a check if you fill out this Claim Form, if the Settlement is approved, and if you are found to be eligible for payment. The Settlement establishes a fund to compensate Settlement Class Members to provide credit monitoring services, reimbursement for their out-of-pocket losses, and/or to provide Settlement Class Members with a pro rata cash payment, as well as for the costs of notice and administration, certain taxes, Service Award payments, and attorney fee awards and costs as awarded by the Court.

The Notice you were mailed describes your legal rights and options. Please visit the Settlement Website, ColumbiaHealthCareDataBreach.com, or call 1-888-887-7407 for more information.

If you wish to submit a claim for benefits, you must provide the information requested below. If submitting by mail, please print clearly in blue or black ink. The deadline to submit this Claim Form online or have it postmarked for mailing is **November 25, 2025**.

Si desea recibir esta notificación o un formulario de reclamo en español, visite la página de documentos en el sitio web del acuerdo.

1. Settlement Class Member Information (All information is required.)

First Name: | MI: | Last Name:

Address:

City: | State: | ZIP Code:

Telephone Number: ___ – ___ – ____

Email Address:

Unique ID (found on postcard notice)*:

* *If you are unable to locate your Unique ID, contact the Settlement Administrator at 1-888-887-7407.*

2. Payment Eligibility Information

Please review the Notice and Section IV of the Settlement Agreement (available at ColumbiaHealthCareDataBreach.com) for more information on who is eligible for payment and the nature of the expenses or losses that can be claimed.

Please provide as much information as you can to help us figure out if you are entitled to benefits.

PLEASE PROVIDE THE INFORMATION LISTED BELOW.

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Credit Monitoring Services:

☐ Check this box if you would like to claim two years of CyEx Medical Shield Complete to monitor medical and healthcare data. The product includes one-bureau credit monitoring, health insurance plan ID monitoring, Medicare beneficiary monitoring, medical record number monitoring, dark web monitoring, health savings account monitoring, national provider identifier monitoring, high-risk transaction monitoring, security freeze assistance, and victim assistance.

Monetary Relief: Settlement Class Members can choose to submit a claim for reimbursement for Documented Losses and/or a Pro Rata Cash Payment. Claimed reimbursements must be supported by documentary evidence.

Reimbursement of Documented Losses

☐ Check this box if you would like to claim reimbursement of up to $10,000 in documented expenses.

Examples: unreimbursed costs, expenses, losses, or charges incurred as a result of identity theft or identity fraud, falsified tax returns, or other possible misuse of your information; costs incurred on or after **December 21, 2023**, and no later than **November 25, 2025**, associated with purchasing or extending additional credit monitoring or identity theft protection services and/or accessing or freezing/unfreezing credit reports with any credit reporting agency; other miscellaneous expenses incurred such as notary, fax, postage, copying, mileage and long-distance telephone charges that were incurred on or after **December 21, 2023**, and no later than **November 25, 2025**

To receive reimbursement for any Documented Loss, Settlement Class Members must submit supporting documentation of the loss and a description of how the loss is fairly traceable to the alleged Data Incident, if not readily apparent from the documentation. Documented Losses can be supported with receipts or other documentation that demonstrates the reasonable costs actually incurred by the Claimant. "Self-prepared" documents, such as handwritten receipts, are, by themselves, insufficient to receive reimbursement but may be considered to add clarity or support other submitted documentation.

Cost Type (Fill all that apply)	**Approximate Date of Loss**	**Amount of Loss**	**Description of Supporting Reasonable Documentation** (Identify what you are attaching and how it relates to the alleged Data Incident)
Bank fees incurred between December 21, 2023, and November 25, 2025	MM – DD – YYYY	$ •	*Example: Bank account statement with charges highlighted*
Long-distance, cell phone, or data charges (only if charged by the minute or for data actually used) incurred between December 21, 2023, and November 25, 2025	MM – DD – YYYY	$ •	*Example: Account statement with charges highlighted*
Postage charges incurred between December 21, 2023, and November 25, 2025	MM – DD – YYYY	$ •	*Example: Receipt of postal expenses*
Gasoline for local travel purchased between December 21, 2023, and November 25, 2025	MM – DD – YYYY	$ •	*Example: Receipt of fuel purchase*
Fees for credit reports purchased between December 21, 2023, and November 25, 2025	MM – DD – YYYY	$ •	*Example: Notice or account statement reflecting payment for a credit report*
Credit monitoring that was ordered between December 21, 2023, and November 25, 2025	MM – DD – YYYY	$ •	*Example: Receipt or account statement reflecting purchase made for expanded identity theft and fraud monitoring services*
Other loss (provide detailed description) incurred between December 21, 2023, and November 25, 2025	MM – DD – YYYY	$ •	
	TOTAL:	$ •	

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Pro Rata Cash Payment

☐ Check this box if you would like to claim a Pro Rata Cash Payment in lieu of or in addition to reimbursement for Documented Losses. Pro Rata Cash Payments will be calculated by dividing the funds remaining in the Settlement Fund after payment of Settlement Administration Fees, Fee Award and Expenses, Service Awards, Credit and Medical Monitoring, and Documented Losses.

How You Will Receive Your Payment

If you made a claim for payment on this Claim Form, and if your claim and the settlement are finally approved, an email from Epiq will be sent to the email address you provided on this Claim Form, prompting you to elect your method of payment. Popular electronic payment options will be available, or you can elect a check.

Please ensure you have provided a current and complete email address. If you do not provide a current and valid email address, the settlement administrator may attempt to send you a check relying on your physical address on file.

3. Signature and Date

By submitting this Claim Form, I certify that I am eligible to make a claim in this Settlement and that the information provided in this Claim Form and any attachments is true and correct. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

I acknowledge that, as of the Effective Date of the Settlement, pursuant to the terms set forth in the Settlement Agreement, and by operation of law and the Final Judgment, I shall be deemed to release and forever discharge and shall be forever enjoined from prosecuting any claims relating to the alleged Data Incident and the Released Claims against Columbia and the Released Parties (as more fully defined in the Settlement Agreement and/or Final Judgment).

I understand that this Claim may be subject to audit, verification, and Court review and that the Settlement Administrator may require supplementation of this Claim or additional information from me. I also understand that all claim payments are subject to the availability of settlement funds and may be reduced in part or in whole, depending on the type of claim and the determinations of the Settlement Administrator.

Signature

Date ☐☐ – ☐☐ – ☐☐☐☐
MM DD YYYY

Print Name

4. Submission Instructions

If mailed, this Claim Form must be postmarked by **November 25, 2025**, and sent to the following address:

Columbia Data Incident Settlement Administrator
P.O. Box 4118
Portland, OR 97208-4118

If submitted online, it must be submitted by 11:59 p.m. ET on **November 25, 2025**, on the Settlement Website, ColumbiaHealthCareDataBreach.com.