Must be postmarked by mail no later than September 12, 2025

SUTTER HEALTH PREMIUM OVERPAYMENT SETTLEMENT
C/O JND LEGAL ADMINISTRATION
PO BOX 91350
SEATTLE, WA 98111
www.SutterHealthPremiumLawsuit.com

SUTTER HEALTH PREMIUM OVERPAYMENT SETTLEMENT CLAIM FORM

You may be eligible to receive a cash payment if:

1. You paid premiums for a fully-insured policy to Aetna, Anthem Blue Cross, Blue Shield of California, Health Net, or United Healthcare (collectively "Health Plans").

2. You paid these premiums sometime between January 1, 2011, and March 8, 2021.

3. While paying premiums, you lived or worked (or, if you are an employer, had an office located) in any of the following counties: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Napa, Nevada, Placer, Plumas, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tuolumne, Yolo, or Yuba.

The Easiest Way to File is Online at www.SutterHealthPremiumLawsuit.com.

INSTRUCTIONS FOR COMPLETING THIS CLAIM FORM

1. **Please provide below, and on page 7, the Unique ID contained in the email or on the postcard notice that you received.** If you did not receive an email or postcard, or if you cannot locate your email/postcard, write "unavailable."

UNIQUE ID:	

2. **Section A**: Please provide your contact information.

3. **Section B:** All claimants must provide their health insurance policy information.

4. **Section C**: Employee and Group claimants may review this section for additional options regarding claim payment.

5. **Section D**: All claimants must complete and provide payment election.

6. **Section E:** You must sign the claim form certification and mail it to the address below, postmarked by **September 12, 2025**, in order for your claim to be considered. Or you can quickly complete this claim form online at www.SutterHealthPremiumLawsuit.com.

   Sutter Health Premium Overpayment Settlement
   C/O JND Legal Administration
   PO Box 91350
   Seattle, WA 98111

7. Please review the checklist on page 8 before submitting your claim.

   By submitting this claim form, you consent to the disclosure and use of your information by the Claims Administrator. The information you provide on this claim is confidential and will be used solely to contact you and process your claim. It will not be used for any other purpose.

8. *To be eligible for a payment, you **must** submit your claim form online or postmarked by **September 12, 2025**. Do not mail or deliver your claim form to the Court.*

SECTION A: CLAIMANT INFORMATION

1. SUBSCRIBER/ COMPANY FULL NAME:			
2. MAILING ADDRESS:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. COMPANY CONTACT: (NAME AND TITLE) (IF APPLICABLE)			
4. PHONE NUMBER:			
5. EMAIL ADDRESS:			
6. IF YOU ARE A GROUP CLAIMANT, PLEASE SELECT ONE OF THE FOLLOWING:	☐ Your company/business/entity paid its premium through another purchasing entity, such as a Professional Employer Organization. Please state the name of the purchasing entity: _____ ☐ You are a Professional Employer Organization, Union or Trade Association, or other associational entity that collected payment for, contracted with or purchased one or more policies from a Health Plan on behalf of your client companies, customers or members. ☐ None of the above.		

SECTION B: HEALTH INSURANCE POLICY INFORMATION

Please provide the following information for each policy on which you paid a premium. If any information is unavailable, you may leave it blank.

If you require more space than the chart below provides, ***you should file online at www.SutterHealthPremiumLawsuit.com****. Or, you may make multiple copies of this page.*

Name of Health Plan	Health Plan Group #	Subscriber ID (For Individuals Only)	Name of employer or group entity through which you paid an insurance premium (if applicable)	Mailing address of employer or group entity (if applicable)	Coverage Start Date (MM/YYYY)	Coverage End Date (MM/YYYY)	Covered Lives (Individual/ Family)

SECTION C: EXPLANATION OF EMPLOYER/EMPLOYEE PREMIUM PERCENTAGES

This Section Only Applies to Employee or Group Claimants.

The Settlement provides that payments will be based, in part, on premiums paid to Health Plans between January 1, 2011 and March 8, 2021.

The Settlement also provides default formulas for the Claims Administrator to use to determine what percentage of the premium was paid by an employer/entity and what percentage was contributed by its employees/members.

> *100% of premiums for employees who do not file claims are allocated to the claiming employer. When an employee does claim, their premium share is determined through the default formulas, which provide that employees with single coverage are allocated 18% of the total premium paid on their behalf by their employer, and employees with family coverage are allocated 29%, with the remainder allocated to the employer. For a full discussion of how these formulas will be used in calculating claims, please refer to the Plan of Distribution at www.SutterHealthPremiumLawsuit.com.*

DEFAULT OPTION

- **If you accept the Default Option**, you are **NOT** required to provide any additional data or evidence in support of your claim at this time.
- If another claimant's filing affects your claim, you will be provided with an opportunity to respond at a later date.

ALTERNATIVE OPTION

- If you want to claim an alternative premium contribution instead of using the Default Option, you must complete the table on page 6 AND provide documents to support the percentages and amounts you list in the table.
- The Claims Administrator will review your documents and make a final decision. For any time period for which supporting data or evidence is not provided, the above Default Option will be applied.
- Selection of the Alternative Option does not ensure a contribution percentage higher than or equal to the Default Option. Your percentage will be dependent on a review process that includes a review of all materials submitted pertaining to your premium.

SECTION C CONTINUED

STOP: If you want to use the DEFAULT OPTION, DO NOT FILL OUT THIS SECTION.

If you would like to use the **ALTERNATIVE OPTION** instead of receiving the Default Option, please state the percentage contribution you believe you contributed for each year that you were enrolled in a Health Plan health insurance.

Year	Percentage (%)	Amount Paid ($)
2011		
2012		
2013		
2014		
2015		
2016		
2017		
2018		
2019		
2020		
2021		

REMINDER: If you choose to apply for an alternative contribution percentage you must supply documentation with this claim form supporting the percentage you claim to have contributed and proof of the amount you paid. If you fill out this chart to apply for an alternative contribution percentage without providing additional documentation, the above Default Option will be applied to your claim.

SECTION D: PAYMENT ELECTION

Please let us know how you would like to receive your settlement payment if your claim is deemed valid. **You may only check one box below**.

Final determinations of claim amounts will not be made until after processing by the Claims Administrator is complete. Claims will not be paid if the value is equal to or less than $5.00.

Claimants who submit valid, approved claims shall receive a pro-rata percentage of the Net Settlement Fund based upon their estimated proportion of the cumulative total of premiums paid by all claimants.

I would like to receive my payment by…

☐ Electronic Debit Card ➔ Email: _____

☐ Check

YOU MUST SIGN AND DATE YOUR CLAIM FORM BELOW IN ORDER TO BE ELIGIBLE TO BE PAID IN THIS SETTLEMENT

SECTION E: SIGNATURE

I affirm under the laws of the United States and the laws of my State of residence that the information supplied in this Claim Form by the undersigned is true and correct to the best of my recollection, and that this form was executed on the date set forth below.

I understand that I may be asked to provide supplemental information to the Claims Administrator before my claim is considered complete and valid.

UNIQUE ID:	

Signature:	**Dated:**
Print Name:	**Title** (if signing on behalf of company/business/entity)**:**

CHECKLIST

- ✓ Did you include your Unique ID on page 2 and page 7? Or, if you do not have a Unique ID, did you write “unavailable”?
- ✓ Did you complete all fields in Sections A, B and C, as applicable?
- ✓ If you elected the Alternative Option in Section C, did you include supporting documentation or information?
- ✓ Did you complete Section D and tell us how you want to receive payment?
- ✓ Did you sign and date the claim form at Section E?
- ✓ Did you mail your form prior to the deadline?

If any of your contact information changes, you must promptly notify us by emailing info@SutterHealthPremiumLawsuit.com.

Please note that Settlement benefits will be distributed after the Settlement is approved by the Court and final. Please be patient.