

OSF Claims Administrator
P.O. Box 990
Corte Madera, CA 94976-0990



OF9

Cynthia Cain and Elizabeth Hahn, individually and on behalf of all others similarly situated v. OSF HealthCare, Case No. 21-L-00231

TENTH JUDICIAL CIRCUIT COURT
PEORIA COUNTY, ILLINOIS

**Must Be Postmarked By
December 15, 2022**

OSF HEALTHCARE DATA INCIDENT SETTLEMENT CLAIM FORM

This Claim Form should be filled out and submitted by mail if you received notice that your Personally Identifiable Information and/or Protected Health Information was potentially compromised in the Data Incident that occurred within OSF HealthCare between March 7, 2021 and April 23, 2021. You may enroll in complimentary credit monitoring services through Pango for a period of two years from the enrollment date. You may also receive a cash payment of (1) \$20 per hour (a maximum of three hours) for time lost spent dealing with the Data Incident and/or (2) up to \$500 for reimbursement of documented ordinary expenses and/or (3) reimbursement for documented extraordinary expenses if you fill out this Claim Form.

Please refer to the Settlement Notice posted on the settlement website, www.OSFHealthcareDataSettlement.com, for more information.

THIS CLAIM FORM MUST BE SUBMITTED ONLINE OR POSTMARKED BY: December 15, 2022.

CLASS MEMBER INFORMATION

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

[Redacted]										[Redacted]									
First Name										Last Name									
Street Address																			
Street Address (continued)																			
City										State					ZIP Code				
Country																			
[Redacted]					—	[Redacted]					—	[Redacted]							
Phone																			
Email (required for Credit Monitoring)																			



FOR CLAIMS PROCESSING ONLY	OB [Redacted]	CB [Redacted]	<input type="radio"/> DOC <input type="radio"/> LC <input type="radio"/> REV	<input type="radio"/> RED <input type="radio"/> A <input type="radio"/> B
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SETTLEMENT BENEFITS

You may submit a claim for both identity theft protection (#1) and one or more cash payments (#2).

1. Identity Theft Protection

You may claim identity theft protection services through Pango for a period of two years by filling in the circle below and submitting this form. No additional documentation is needed.

YES, please provide me with credit monitoring services.

Please provide your email address above. After the settlement becomes effective, you will receive via email an activation code to use to enroll directly with Pango. You must both file this Claim Form and use the code that will be sent to you to enroll in the service in order to receive the identity theft protection services.

2. Cash Payments

Three types of cash payments for damages are available. First, you may recover payment to compensate you for the time you spent dealing with the Data Incident (#A). Second, you may recover certain “ordinary expenses” incurred as a result of the Data Incident (#B). Third, you may recover certain “extraordinary expenses” incurred as a result of the Data Incident (#C). These expenses or time must have been incurred during the applicable time period, which is between October 1, 2021 and December 15, 2022. Please refer to the Settlement Notice for more information.

To help us determine if you are entitled to a settlement payment, please provide as much information as possible.

Only complete the sections for which you are making a claim for a cash payment. You may make a claim for any or all of the following types of damages:

A. Lost Time.

You may be eligible for reimbursement of up to three hours of time spent dealing with the Data Incident (at \$20 per hour) with an attestation that the time was spent dealing with the Data Incident.

How much time did you spend (in hour increments)?

(a maximum of 3 hours will be considered for reimbursement regardless of whether the time spent exceeded 3 hours)

Attestation (you must fill in this circle to attest to the number of hours you are claiming)

I attest that I spent the number of hours claimed above making reasonable efforts to deal with the Data Incident.

Any payments made under this section will be deemed a part of the \$500 maximum for all payments made under sections A and B.

B. Documented Ordinary Expenses.

The types of ordinary expenses that you may claim include fees or other charges (e.g., unreimbursed bank fees related to fraud or identity theft, credit monitoring, etc.) and other incidental expenses (e.g., postage, long distance charges, etc.) you incurred addressing the Data Incident. The Settlement Notice further describes the types of available expenses in greater detail and the documentation required to support the expenses. Please refer to that document for more information.

Date	Description	Amount
		\$ ____ . ____
		\$ ____ . ____
		\$ ____ . ____
		\$ ____ . ____
		\$ ____ . ____
Total Amount of Ordinary Expenses Claimed		\$ ____ . ____



Documentation is required for claimed expenses. Please be sure to include documentation to expedite the processing of your claim. For example, a bank statement showing claimed fees (you may redact unrelated transactions and all but the last four digits of any account number).

Settlement Class Members may claim up to **\$500 in total** for payments made under sections A and B.

C. Documented Extraordinary Expenses

The types of extraordinary expenses that you may claim include expenses associated with identity theft, medical fraud, tax fraud, other forms of fraud, and other actual misuse of personal information, provided that (i) the loss is an actual documented and unreimbursed monetary loss; (ii) the loss was more likely than not caused by the Data Incident; (iii) the loss is not already covered by one or more of the ordinary loss compensation categories under Claim B; (iv) you made reasonable efforts to avoid the loss or seek reimbursement for the loss, including, but not limited to, exhaustion of all available credit monitoring or identity monitoring insurance; and (v) the loss occurred between October 1, 2021 and December 15, 2022.

The Settlement Notice describes the types of available expenses in greater detail and the documentation required to support the expenses. Please refer to that document for more information.

Date	Description	Amount
		\$ _____ . ____
		\$ _____ . ____
		\$ _____ . ____
		\$ _____ . ____
		\$ _____ . ____
Total Amount of Extraordinary Expenses Claimed		\$ _____ . ____

Documentation is required for claimed extraordinary expenses. Please be sure to include documentation to expedite the processing of your claim.

Settlement Class Members seeking reimbursement of \$750 or more must provide the following information:

Gender					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%; height: 20px; border: 1px solid black;"></td> <td style="width: 5%; text-align: center;">/</td> <td style="width: 20%; height: 20px; border: 1px solid black;"></td> <td style="width: 5%; text-align: center;">/</td> <td style="width: 50%; height: 20px; border: 1px solid black;"></td> </tr> </table>		/		/	
	/		/		
Date of Birth (MM/DD/YYYY)					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 40%; height: 20px; border: 1px solid black;"></td> <td style="width: 20%; text-align: center; vertical-align: middle;">OR</td> <td style="width: 40%; height: 20px; border: 1px solid black;"></td> </tr> </table>		OR			
	OR				
Last five digits of Social Security Number					
Full Medicare Beneficiary Identification Number					

The information supplied in this Claim Form is true and correct to the best of my recollection. I understand that I may be asked to provide supplemental information by the Claims Administrator before my claim will be considered complete and valid.

Signature: _____ Date (mm/dd/yyyy): _____

Print Name: _____

The deadline to submit this Claim Form and all required supporting documentation is December 15, 2022.

This Claim Form may be submitted online at www.OSFHealthcareDataSettlement.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, along with any supporting documentation, by U.S. Mail to:

OSF Claims Administrator
P.O. Box 990
Corte Madera, CA 94976-0990

DO NOT SEND THIS CLAIM FORM TO THE COURT

Questions? Call 1-844-403-1014 or visit www.OSFHealthcareDataSettlement.com

