CLAIM FORM FOR THE HUMANA SETTLEMENT FUND AND ELECTION OF CONTRIBUTION TO CHARITABLE FOUNDATION

You must read the Notice of Proposed Settlement and Claim Instructions before completing this Claim Form.

SECTION A: CLAIMANT INFORMATION – ALL CLAIMANTS MUST COMPLETE THIS SECTION.

☐ **Physician Group/Organization** Please indicate the number of physicians on your list ___________

Physician Group or Organization Name	
Name and Title of Person Filing	*Phone*

*** Groups/Organizations must attach a list of Active Physicians along with key information specified in the Instructions enclosed with this mailing.**

☐ **An Individual Physician** Please indicate your physician type (e.g., MD or DO) ___________

Name of Physician	
Name of Representative *(if Physician is Deceased)*	*Phone*

* If you are the legal heir or representative of a deceased Class Member, you must attach documentation such as a death certificate or letters of administration for an estate to confirm your status. The Tax ID requested in Section E is that of the heir or estate.

Mailing Address for Groups or Individual Claimants

Mailing Address (Street, PO Box, Suite or Office Number, as applicable)			
City	*State*	*Zip Code*	*Humana Provider Number (if applicable)*

Individual Claimants, please check the appropriate box in SECTION B or SECTION C to indicate of which category you are a member. Groups and Organizations do not need to complete sections B or C.

SECTION B: I AM A MEMBER OF THE CLASS WHO HAS RETIRED FROM THE PRACTICE OF MEDICINE SUBSEQUENT TO JANUARY 1, 1990 OR I AM THE LEGAL HEIR OR REPRESENTATIVE OF A DECEASED CLASS MEMBER.

☐ By checking the box to the left, I certify that I have reviewed the enclosed Notice of Proposed Settlement and that I am either a Class Member (as described in the enclosed Notice of Proposed Settlement) who has retired from the practice of medicine subsequent to January 1, 1990 or that I am the legal heir or representative of a deceased Class Member.

SECTION C: I AM A MEMBER OF THE CLASS AND AN ACTIVE PHYSICIAN.

☐ By checking the box to the left, I certify that I have reviewed the enclosed Notice of Proposed Settlement and that I am a Class Member (as described in the enclosed Notice of Proposed Settlement) and that I am an Active Physician.

Active Physicians check **ONLY ONE** of the boxes below to designate the range of gross receipts that are the basis of this claim. Groups need to attach a list that designates the range of gross receipts for each Active Physician group member. *For purposes of determining this amount, “Humana” means any of the present or former affiliates as listed in the Notice at Exhibit 1.*

☐ By checking this box, I certify that I received no payments from Humana or that my gross receipts for providing covered services to Humana members during the three calendar year period of 2003, 2004, and 2005 were less than $5,000.

☐ By checking this box, I certify that my gross receipts for providing covered services to Humana members during the three calendar year period of 2003, 2004, and 2005 were at least $5,000 but less than $50,000.

☐ By checking this box, I certify that my gross receipts for providing covered services to Humana members during the three calendar year period of 2003, 2004, and 2005 were $50,000 or greater.

☐ By checking this box, I certify that my gross receipts for providing covered services to Humana members during another consecutive three-year period between January 1, 1996 and December 31, 2005 were in the amount

shown on Page 2 and are supported by the enclosed documents evidencing such receipts.

If you checked boxes I, II or III in Section C on Page 1, please move to Section D.

If you checked box IV in Section C on Page 1, please complete the table below.

If you checked Box IV in Section C, please indicate in the table below the dates of the three-year period that are the basis of your claim and check the appropriate box to indicate for this three-year period the range of gross receipts you received for providing covered services to Humana members. You must attach your proof or receipts and write a description of the proof you attached in the box below.

	☐ under $5,000	☐ $5,000 - <$50,000	☐ $50,000 or over
Dates of the 3 – Year Period	*Description of the Proof Attached.*		

SECTION D: INSTRUCTIONS FOR PAYMENT – ALL CLAIMANTS MUST COMPLETE THIS SECTION.

☐ By checking this box, I am directing the Settlement Administrator to remit payment of the *pro rata* portion of the settlement fund for an eligible claim directly to me (i.e., to the Class Member completing this claim, which may be an individual or group/organization).

☐ By checking this box, I am directing the Settlement Administrator to donate the *pro rata* portion of the settlement fund for an eligible claim to the charitable foundation that I have selected from the List of Charitable Foundations found on the bottom of Page 2 of the Claim Form Instructions (select only one charitable foundation).

CLEARLY print the number preceding the Foundation you are selecting from the List of Charitable Foundations found on the bottom of Page 2 of the Claim Form Instructions.

Foundation Designation Number

SECTION E: SUBSTITUTE W-9 – ALL CLAIMANTS MUST COMPLETE THIS SECTION.

On the appropriate line, enter the Social Security Number or Employer Identification Number of the claimant whose name will appear on any check and related Form-1099. For individuals, this is your Social Security Number (SSN). For groups, this is your Employer Identification Number (EIN).

_________ - ______ - ____________ **OR** ______ - ______________________

Social Security Number (SSN) Employer Identification Number (EIN)

By signing this Claim Form, I certify that:

1. The number shown on this form above is the correct Social Security Number or Employer Identification Number for this claimant; and
2. The claimant is not subject to backup withholding because the claimant: (a) is exempt from backup withholding, or (b) has not been notified by the Internal Revenue Service (IRS) that the claimant is subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified the claimant that the claimant is no longer subject to backup withholding.

NOTE: Backup withholding is extra tax withholding that occurs when a taxpayer has underreported interest or dividends in a previous year. The IRS notifies taxpayers who are subject to backup withholding. If you (the claimant) have been notified by the IRS that you are subject to backup withholding because you have failed to report all interest and dividends on your tax return, you must cross out item 2 above by placing a line through the section.

SECTION F: CERTIFICATION – ALL CLAIMANTS MUST COMPLETE THIS SECTION

I do declare and certify as follows:

- I am a Class Member or an authorized representative of the Physician Group or Organization identified above; and
- All of the statements and information provided in this Claim Form are true, correct and complete.

NOTE: The Internal Revenue Service does not require your consent to any provision of this document other than the certifications in Section E required to avoid backup withholding.

______________________________________ ____________________

Signature of Class Member or Authorized Representative for Group Date

Any Claim Form postmarked after February 17, 2006 will be considered to be late and will be denied.

Claims must be sent to the Humana Settlement Administrator at PO Box 4068; Portland, OR 97208-4068.

If you have any questions, please call the Administrator at 1-866-833-7919.