CLAIM FORM FOR LOGAN HEALTH DATA BREACH BENEFITS

USE THIS FORM TO MAKE A CLAIM FOR REIMBURSEMENT OF OUT-OF-POCKET LOSSES, AND/OR ATTESTED TIME, CREDIT MONITORING SERVICES, OR AN ALTERNATIVE CASH PAYMENT.

If you would like to receive a digital payment, please submit your Claim Form online at www.LoganHealthSettlement.com. Para una notificación en Español, llamar 1-888-317-0380 o visitar nuestro sitio web www.LoganHealthSettlement.com.

The DEADLINE to submit this Claim Form is postmarked: April 3, 2023

I. GENERAL INSTRUCTIONS

If you are an individual whose Personal Information was compromised as a result of a data breach that occurred when the network systems of Logan Health Medical Center ("Logan Health") were hacked in a sophisticated criminal cyberattack affecting certain Logan Health files containing the personal and health information of Logan Health's patients and other affiliated persons (the "Data Security Incident") you are a Class Member.

As a Class Member, you are eligible to make a claim for **one or more of the following**:

- **Reimbursement for Out-of-Pocket Losses:** all Class Members may submit a claim for up to \$25,000 for reimbursement of Out-of-Pocket Losses that are fairly traceable to the Data Security Incident, which must be supported by (i) third-party documentation supporting the loss; and (ii) a brief description of the nature of the loss. A claim for Out-of-Pocket Losses may be combined with with reimbursement for Attested Time but in no circumstance will a Settlement Class Member be eligible to receive more than the \$25,000.00.
- **Reimbursement for Attested Time:** all Class Members may submit a claim for reimbursement of Attested Time up to five (5) hours at \$25 per hour, which must be supported by a brief description of the actions taken in response to the Data Security Incident and the time associated with each action. A claim for Attested Time may be combined with with reimbursement for Out-of-Pocket Losses but in no circumstance will a Settlement Class Member be eligible to receive more than the \$25,000.00.

In addition to claiming reimbursement for Out-of-Pocket Losses and/or Attested Time, Class Members are also eligible to make a claim for **either**:

- Credit Monitoring Services: a Class Member may submit a claim for up to three (3) years of Credit Monitoring Services through Global Cyber Group for Intersections, LLC d/b/a Pango, regardless of whether the Class Member submits a claim for reimbursement of Out-of-Pocket Losses or Attested Time. A Class member cannot submit a claim for both Credit Monitoring Services and an Alternative Cash Payment under the Settlement.
 - o **Minor Monitoring Services:** Class Members under the age of eighteen (18) on or before the Claims Deadline are automatically eligible to enroll in Minor Monitoring Services provided by Pango for a period of three (3) years from the Effective Date, regardless of whether they submit a claim under the Settlement.

OR:

• Alternative Cash Payment: in lieu of Credit Monitoring Services, a Class Member who is not automatically eligible for Minor Monitoring Services may elect to receive a cash payment in an amount equal to a pro rata distribution of the Net Settlement Fund but, in no event, to exceed \$125.

If a Participating Settlement Class Member attempts to claim both Credit Monitoring Services and Alternative Cash Payment under the Settlement, the Settlement Administrator is authorized to contact the Settlement Class Member (by e-mail, telephone, or U.S. mail) to seek clarification regarding which benefit he or she would like to select.

The Settlement Administrator shall send an activation code to each Participating Settlement Class Member who is eligible for Crediting Monitoring Services within thirty (30) days of the Effective Date which can be used to activate Credit Monitoring Services via an enrollment website maintained by Pango. Such enrollment codes shall be sent via e-mail, unless the claimant did not provide an e-mail address, in which case such codes shall be sent via U.S. mail. Credit Monitoring Services claimants may activate Credit Monitoring Services for a period of at least 60-days from the date the Settlement Administrator sends the activation code. Pango shall provide Credit Monitoring Services to all valid claimants who timely activate those services for a period of three (3) years from the date of activation.

Cash payments amounts may be reduced pro rata (equal share) or increased pro rata depending on how many Class Members submit claims. Complete information about the Settlement and its benefits are available at www.LoganHealthSettlement.com.

This Claim Form may be submitted online at www.LoganHealthSettlement.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, by U.S. mail to:

Logan Health Data Breach Settlement Administrator c/o CPT Group, Inc. 50 Corporate Park Irvine, CA 92606

II. CLAIMANT INFORMATION

The Settlement Administrator will use this information for all communications regarding this Claim Form and the Settlement. If this information changes prior to distribution of cash payments and Credit Monitoring Services, you must notify the Settlement Administrator in writing at the address above.

First Name											M.I. Last Name																		
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You may only select one of the following options:

III. CLASS MEMBERSHIP

	ase check this box if you received a notice related to this Class Action and provide your Unique CPT Number in Section II above.
the	ase check this box if you have not received a letter notice but believe that you should be included in Class. You must provide Reasonable Documentation demonstrating that you were impacted by the gan Health Data Security Incident.
	You may select either:
	IV. CREDIT MONITORING SERVICES
your Clai	you wish to receive Credit Monitoring Services, you must check off the box for this section, provide ar email address in the space provided in Section II, above, and return this Claim Form. Submitting this aim Form will not automatically enroll you into Credit Monitoring Services. To enroll, you must follow instructions sent to your email address after the Settlement is approved and becomes final (the fective Date").
	Or, in the alternative:
	V. ALTERNATIVE CASH PAYMENT
simj as th	you wish to receive a Alternative Cash Payment, you must check off the box for this section, and then apply return this Claim Form. An Alternative Cash Payment will be made for an approved Claim as long the Net Settlement Fund is not depleted by the claims for Credit Monitoring Services, Reimbursment Out-of-Pocket Losses and Reimbursement for Attested Time.
	You may also select one or more of the following:
	VI. REIMBURSEMENT FOR OUT-OF-POCKET LOSSES
Out- and and	ase check off this box for this section if you are electing to seek reimbursement for up to \$25,000 of t-of-Pocket Losses you incurred that are fairly traceable to the Logan Health Data Security Incident are not otherwise reimbursable from insurance. Out-of-Pocket Losses include unreimbursed losses I consequential expenses that are more likely than not related to the Logan Health Data Security ident and incurred on or after November 22, 2021.
and/or on a	make a claim for Reimbursement of Out-of-Pocket Losses, you must (i) fill out the information below a separate sheet submitted with this Claim Form; (ii) sign the attestation at the end of this Claim Form; and (iii) include third party documentation supporting each claimed cost along with this Claim Form.

In order to make a claim for Reimbursement of Out-of-Pocket Losses, <u>you must</u> (i) fill out the information below and/or on a separate sheet submitted with this Claim Form; (ii) sign the attestation at the end of this Claim Form (section X); and (iii) include third party documentation supporting each claimed cost along with this Claim Form. Out-of-Pocket Losses need to be deemed more likely than not due to the Logan Health Data Security Incident by the Settlement Administrator based on the documentation you provide and the facts of the Logan Health Data Security Incident. <u>Failure to meet the requirements of this section may result in your claim being rejected by the Settlement Administrator.</u>

Cost Type (Fill all that apply)	Approximate Date of Loss	Amount of Loss	Description of Supporting Reasonable Documentation (Identify what you are attaching and why)
O Unreimbursed fraud losses or charges	(mm/dd/yy)	\$.	Examples: Account statement with unauthorized charges highlighted; Correspondence from financial institution declining to reimburse you for fraudulent charges
O Professional fees incurred in connection with identity theft or falsified tax returns	(mm/dd/yy)	\$	Examples: Receipt for hiring service to assist you in addressing identity theft; Accountant bill for re-filing tax return
O Lost interest or other damages resulting from a delayed state and/or federal tax refund in connection with fraudulent tax return filing	(mm/dd/yy)	\$	Examples: Letter from IRS or state about tax fraud in your name; Documents reflecting length of time you waited to receive your tax refund and the amount
O Credit freeze	(mm/dd/yy)	\$	Examples: Notices or account statements reflecting payment for a credit freeze:
O Credit monitoring that was ordered after November 22, 2021 through the date on which the Credit Monitoring Services become available through this Settlement	[\$	Example: Receipts or account statements reflecting purchases made for credit monitoring services
O Miscellaneous expenses such as notary, fax, postage, copying, mileage, and long- distance telephone charges	(mm/dd/yy)	\$	Example: Phone bills, gas receipts, postage receipts; detailed list of locations to which you traveled (i.e. police station, IRS office), indication of why you traveled there (i.e. police report or letter from IRS re: falsified tax return) and number of miles you traveled to remediate or address issues related to the Logan Health Data Security Incident.
O Other (provide detailed description)	(mm/dd/yy)	\$	Please provide detailed description below or in a separate document submitted with this Claim Form:

If you do not submit third party documentation supporting a Reimbursement for Out-of-Pocket Losses claim, or your claim for a Reimbursement for Out-of-Pocket Losses claim is rejected by the Settlement Administrator for any reason and you do not cure the defect, you will not be eligible to receive reimbursement for such losses.

VII. REIMBURSEMENT	FOR ATTESTED TIME
you undertook to prevent or mitigate fraud and	are electing to seek reimbursement for Attested Time identity theft following the announcement of the Data submit a Claim for reimbursement of Attested Time rate of \$25 per hour, for a maximum of \$125.
	the nearest hour and check only one box) that you cheft following the announcement of the Logan Health
☐ 1 Hour ☐ 2 Hours ☐ 3 Hours	□ 4 Hours □ 5 Hours
	stomer service lines, writing letters or emails, or on the or reimbursed. Please note that the time it takes to fill out this cluded in the total number of hours claimed.
	the in an attempt to prevent fraud or identity theft, in the space of letters or emails that you wrote. If the time was spent trying describe what you did.
VIII. METHOD	OF PAYMENT
If you have selected a payment for Out-of-Pocket Losses Cash Payment, a physical check will be mailed to the ad like to receive a digital payment, please submit your Cla	dress you provided in Section II, above. If you would
IX. CERTI	FICATION
By submitting this Claim Form, I certify that I am el information provided in this Claim Form and any attact perjury under the laws of the United States of America this claim may be subject to audit, verification, and Corequire supplementation of this Claim or additional in payments are subject to the availability of settlement funt the type of claim and the determinations of the Settlement	hments are true and correct. I declare under penalty of that the foregoing is true and correct. I understand that ourt review and that the Settlement Administrator may afformation from me. I also understand that all claim ds and may be reduced in part or in whole, depending or
Signature	Date
Print Name	

X. ATTESTATION (REQUIRED FOR REIMBURSEMENT OF OUT-OF-POCKET EXPENSES AND ATTESTED TIME CLAIMS)

I,, declare that I suffered t	he Attested Time and/o	or incurred Out-of-Pock	tet Losses claimed
above.			
I also attest that the Attested Time and/or incurrence otherwise reimbursable by insurance.	red Out-of-Pocket Loss	es claimed above are ac	ccurate and were
I declare under penalty of perjury under the law foregoing is true and correct. Executed on		e United States of Ame	rica that the
	[Date]	[City]	[State]
	[Signature]	