Instructions for Submitting Your Uninsured Consumer Claim Form

If you are a member of the Class as an uninsured consumer, you may file a claim for a share of the Settlement Fund. You must complete this Claim Form and mail it to the Notice and Claims Administrator at the address provided below or submit your claim online at www.dvtmedslawsuit.com. **no later than September 1, 2020**.

- To complete this form:

1. Complete all required portions of the attached Claim Form.
2. Complete *Section A* of the attached Claim Form.
3. Answer the question in *Section B* to determine your eligibility.
4. Provide information about your total purchases of Lovenox® or generic enoxaparin in *Section C*.
5. If possible, provide documentation of at least one purchase of Lovenox® or generic enoxaparin as described in *Section D*.
6. Review and sign the Claim Form in *Section E*, which includes the Certification that the information you provide is true and correct to the best of your knowledge. If you submit the form electronically, your electronic signature and submission of the form will be the same as if you signed the form on paper.

- By signing and submitting the Claim Form, you are swearing under penalty of perjury that you qualify to submit a claim according to the criteria given in Section B.
- You have two options for completing a Claim Form:
    - o You can mail the completed and signed Claim Form and Certification by First-Class U.S. Mail, postage prepaid, postmarked no later than September 1, 2020, to:

Enoxaparin Antitrust Settlement
c/o A.B. Data, Ltd.
P.O. Box 173090
Milwaukee, WI 53217

OR

- o You can complete and submit the Claim Form and Certification using the Notice and Claims Administrator's Settlement Website, www.dvtmedslawsuit.com. When you complete the online Claim Form, you will receive an acknowledgement that your claim has been submitted. If you choose this option and file a claim electronically, your electronic signature and submission of the form will conform to the requirements of the Electronic Signatures Act, 15 U.S.C. § 7001, et seq., and will have the same force and effect as if you signed the Claim Form in hard copy.

- If your completed Claim Form is not postmarked or filed online by **September 1, 2020**, you will not receive any payment from the Settlements. Submission of this Claim Form does not ensure that you will share in the payments related to the Settlements.
- If the Notice and Claims Administrator disputes a material fact about your Claim, you will have the right to present information in a dispute resolution process. For more information on this process, visit www.dvtmedslawsuit.com.

MUST BE POSTMARKED ON OR BEFORE SEPTEMBER 1, 2020

Enoxaparin Antitrust Settlement
Case No. 15-cv-01100

Uninsured Consumer Claim Form

Use Blue or Black Ink Only

Attention: This Form Is Only to Be Filled Out for an Uninsured Consumer and Not Third-Party Payors or Hospitals

Section A: Claimant Identification

Claimant's Name

Agent/Legal Representative (if any)

Street Address

City | State | Zip Code

Daytime Telephone Number | E-Mail Address*

*By providing your e-mail address, you authorize the Notice and Claims Administrator to use it to give you information relevant to this claim.

Section B: Should I File a Claim Form?

The Class includes hospitals, third-party payor, and people without insurance. As a person without insurance who bought Lovenox® or generic enoxaparin, you must meet the following definition to be eligible for cash from the Settlements:

1) You must have purchased Lovenox® or generic enoxaparin from a pharmacy;

2) At some point from September 21, 2011 through September 30, 2015;

3) In **Arizona, Arkansas, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia, or Wisconsin**; and

4) For personal consumption by yourself or someone else.

Additionally, you must have purchased at least some generic enoxaparin. If you purchased only branded Lovenox, you are not in the Class. However, if you purchased both generic enoxaparin and branded Lovenox, you can make a claim for both kinds of drugs.

The lawsuit does not include employees of the Defendants or members of the Judges' immediate families.

If you previously excluded yourself from the Class, you may not file a claim.

Section C: Purchase Information

Provide as much of the following information as possible:

1) the total amount of the Class Member's out-of-pocket payments for purchases of Lovenox® or generic enoxaparin from a pharmacy in any of the states listed in Part B during the period from September 21, 2011 through September 30, 2015, and

2) the number and dosage/strength of the syringes purchased (e.g., 40mg/0.4ML) during the same time period if that information is available.

TOTAL AMOUNT YOU PAID FOR LOVENOX®	$
TOTAL SYRINGES OF LOVENOX® PURCHASED (LIST DOSAGE)	
TOTAL AMOUNT YOU PAID FOR GENERIC ENOXAPARIN	$
TOTAL SYRINGES OF GENERIC ENOXAPARIN PURCHASED (LIST DOSAGE)	

Section D: Proof of Payment

Any one of the following is acceptable as claim documentation:

1) Receipts, cancelled checks, or credit card statements that show a payment for Lovenox® or generic enoxaparin;
2) Records from your pharmacy showing that you paid for Lovenox® or generic enoxaparin;
3) A note from your doctor (or records) describing the amount of Lovenox® or generic enoxaparin you were prescribed.

Note: You may have a claim even if you cannot provide any of the above proof of payment as long as you provide the certification below. However, if you do not provide the above information, the Notice and Claims Administrator may ask for additional proof of payment after you submit your Claim Form, so please keep all records of your purchases.

Section E: Certification

I have read and am familiar with the contents of the Instructions accompanying this Claim Form. I certify that the information I have set forth in the above Claim Form and in any documents attached by me are true, correct and complete to the best of my knowledge. I certify that I or the Class Member I represent

1) paid the total amount set forth above in out-of-pocket expenditures for purchases for purchases of Lovenox® or generic enoxaparin (or bought the total number of syringes indicated) in **Arizona, Arkansas, California, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, South Dakota, Tennessee, Utah, Vermont, West Virginia, and Wisconsin** during the period from September 21, 2011 through September 30, 2015;

2) did not have insurance when the payment was made;

3) purchased the Lovenox® or generic enoxaparin from a pharmacy; and

4) purchased at least some generic enoxaparin and did not only purchase branded Lovenox, as opposed to generic enoxaparin or a mix of both.

I further certify that I or the Class Member I represent did not opt out of the Class in this Action and did not purchase such Lovenox® or generic enoxaparin for purposes of resale. In addition, I have not (or the represented Class Member has not) served as counsel, officer, director, agent, or employee of any of the Defendants, or a corporate parent, subsidiary, affiliate, or other related entity thereof; or served as a judge or justice assigned to hear any aspect of this lawsuit.

To the extent I have been given authority to submit this Claim Form by a Class Member on its behalf, and accordingly am submitting this Claim Form in the capacity of an Authorized Agent with authority to submit it by the Class Member identified on a separate sheet of paper submitted with this form, and to the extent I have been authorized to receive on behalf of this Class Member(s) any and all amounts that may be allocated to it from the Settlement Fund, I certify that such authority has been properly vested in me and that I will fulfill all duties I may owe the Class Member. If amounts from the Settlement Fund are distributed to me and a Class Member later claims that I did not have the authority to claim and/or receive those amounts on its behalf, I and/or my employer will hold the Class, counsel for the Class, and the Notice and Claims Administrator harmless with respect to any claims made by the Class Member.

I hereby submit to the jurisdiction of the United States District Court for the Middle District of Tennessee for all purposes connected with this Claim Form, including resolution of disputes relating to this Claim Form. I acknowledge that any false information or representations contained herein may subject me to sanctions, including the possibility of criminal prosecution. I agree to supplement this Claim Form by submitting documentary backup for the information provided in this form, upon request of the Notice and Claims Administrator.

I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Claim Form was executed this _____ day of _____, 20____.

Signature

Print or Type Name

Mail the completed Claim Form postmarked on or before **September 1, 2020**, along with proof of payment, if available, to the following address:

Enoxaparin Antitrust Settlement
c/o A.B. Data, Ltd.
P.O. Box 173090
Milwaukee, WI 53217
Toll-Free Telephone: 1-888-208-9630
Website: www.dvtmedslawsuit.com

Reminder Checklist:

1. Please complete and sign the above Claim Form. Attach or upload any documentation supporting your claim.
2. Keep a copy of your Claim Form and supporting documentation for your records.
3. If you would also like acknowledgement of receipt of your Claim Form, please complete the form online or mail this form via Certified Mail, Return Receipt Requested.
4. If you move and/or your name changes, please send your new address and/or your new name or contact information to the Notice and Claims Administrator via the Settlement Website or U.S. Mail (the addresses are listed above).