For Official Use Only

Must Be Returned Within 30 days of Date Mailed to you (Postmark Date) or if Printed from Website, 30 days after the Web Print Date

CLAIM FORM

In Re: Conrad v. Perales Settlement

If you are the heir of someone who was covered by both Medicare and New York's Medicaid and resided in a Nursing Home any time during January 1, 1989 through December 31, 1989, you may be eligible for payment from the Conrad v. Perales Settlement.

CLAIMANT INFORMATION (Please print or type)

SECTION A:

Name: ____

Address: ____

____

1. **Home Phone No.**: (_____)__________________
2. **Daytime Phone No.**: (_____)__________________
3. **Your Relationship to Class Member** (See Section B below.)*: ______________________

*__NOTE__: You may be required to provide documentation of your relationship or capacity (executor, administrator, legal representative, etc.).

CLASS MEMBER INFORMATION (Please print or type)

SECTION B*:*

1. Class Member's Name: ____
2. Date of Death: ____

SECTION C*:* Please fill in the appropriate box completely (i.e. ■) for each answer

1. Did the Class Member leave a Will? ☐ Yes (attach a copy, if available) ☐ No ☐ Don't Know
2. Was there a Probate proceeding to settle the Class Member's Estate? ☐ Yes ☐ No ☐ Don't Know
3. Are or were you the Executor ☐ Yes ☐ No
   Administrator ☐ Yes ☐ No of the Class Member's Estate?

SECTION D*:*

1. Do you have any living parents, brothers, sisters or first cousins who are related to the Class Member identified in Section B? ☐ Yes ☐ No
2. Are you aware of any other individual(s) that might be entitled to share in the Settlement award for the Class Member identified in Section B? ☐ Yes ☐ No

If you answer YES to either question, please provide, on a separate sheet of paper, the names of the individual(s) and their relationship to the Class Member. Be sure to print clearly or type the information.

Please complete both sides of this claim form and mail to the Settlement Administrator, ***within thirty (30) days of the date this form was mailed to you (postmark date) or printed from website (web print date)***, at the address indicated on page 2.

Complete the Signature Section Below.

FULL AND GENERAL RELEASE

By signing below, I hereby swear or affirm, on my own behalf and/or on behalf of any individuals identified in Section D, that as a Claimant of the Settlement Class, I acknowledge that if the Settlement is finally approved by the Court and becomes effective, the Claimant will unconditionally, fully and finally release and discharge forever the Defendants, including Cesar Perales, Antonia Novello, and the New York State Department of Health and their officers, agents, subdivisions, agencies, and employees, past, present, or future, from all claims, demands and liability of every kind and nature, legal or equitable, occasioned by or arising out of the facts set forth in this action, as made in this action or any other action previously filed or filed at any subsequent date and further acknowledge that I will hold the Settlement Class, counsel for the Settlement Class, and the Settlement Administrator harmless with respect to any claims relating to the distribution of the proceeds of the check.

I declare, under penalty of perjury, that all the information provided in this form is true, correct and complete. I understand that filing a false claim constitutes a federal criminal offense under 18 U.S.C. § 1621 and § 1623. All of the information set forth above is true and correct to the best of my knowledge, information, and belief.

____ ___/___/___
Signature Date

____
Print Name

(Note: In order for your submission to be valid, you **must** sign and date the claim form.)

NOTE that if this claim is approved, the settlement check will be made out to the individual filing the claim and said individual will bear sole responsibility to ensure that the settlement check is distributed to any heirs, survivors, or estate.

NOTE: Complete Claim Solutions, LLC ("CCS") serves only in an administrative capacity and is not an agent of any individual or estate, nor is it an executor, executrix, trustee or estate administrator or an agent of any of the foregoing. You have been identified as a potential payee of the referenced claim or as a relative and/or heir of such individual. If this claim is approved, you will be solely and exclusively responsible for the disposition of the claim proceeds. By negotiating the check, you agree to hold CCS, the Class, all counsel, the defendants and the Settlement fund harmless from and against all claims relating to the distribution of the proceeds of the check by you or anyone acting on your behalf.

MAIL WITHIN THIRTY (30) DAYS OF THE DATE THIS FORM WAS MAILED TO YOU (POSTMARK DATE) TO:

In re: Conrad v. Perales Settlement
c/o Complete Claim Solutions, LLC
P.O. Box 24741
West Palm Beach, FL 33416

If you have any questions about how to fill out any of the blanks in this form, please call the Settlement Administrator, toll-free, at 1-866-478-3441 or visit the website www.nursinghomesettlement.com.

Form downloaded: Monday, September 06, 2010