

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

MDL NO.: 1334

IN RE: MANAGED CARE LITIGATION

THIS DOCUMENT RELATES ONLY TO
PROVIDER TRACK CASES

**CIGNA HEALTHCARE PHYSICIAN SETTLEMENT
COMPLIANCE DISPUTE CLAIM FORM**

The undersigned hereby declares that he, she or it is a Class Member and did not Opt Out of the CIGNA Healthcare Physician Settlement Agreement.

Name _____

Address _____

Tax Identification Number _____

CIGNA HealthCare Provider Number
(if applicable) _____

E-mail Address _____

Telephone Number _____

Signature _____

Date _____

Check one of the following:

I am bringing this Compliance Dispute on my own behalf.

I hereby authorize the following Signatory Medical Society to bring this Compliance Dispute on my behalf: _____

Set forth in detail below, using particularized facts, the specific obligation(s) of CIGNA HealthCare to you under Section 7 of the Settlement Agreement which you allege CIGNA HealthCare has materially failed to perform. Describe how you have been adversely affected by CIGNA HealthCare's alleged failure to comply with those specific obligation(s). You may attach supporting documentation or affidavit testimony.

You must complete and submit this petition no later than thirty (30) days after the Compliance Dispute first arose to:

Compliance Dispute Facilitator
