

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
Miami Division

IN RE: MANAGED CARE LITIGATION

MDL NO. 1334

THIS DOCUMENT RELATES ONLY TO
PROVIDER TRACK CASES

MASTER FILE NO.
00-1334-MD-MORENO

CHARLES B. SHANE, M.D., et al.
Plaintiffs,

v.

Case No. 04-21589-
CIV-MORENO

HUMANA INC., et al.,
Defendants.

KENNETH A. THOMAS, M.D., et al.
Plaintiffs

v.

Case No. 03-21296
CIV-MORENO

BLUE CROSS AND BLUE SHIELD
ASSOCIATION, et al.,
Defendants.

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

DEADLINE FOR SUBMISSION: Postmarked by [insert date that is 90 days after the notice date]

If you would like the portion of the settlement fund that you are entitled to receive to be donated to a charitable foundation that is dedicated to promoting high quality healthcare, you may do so by selecting from one of the charitable foundations listed on Exhibit A1 hereto.

If you validly submit this form to the Settlement Administrator prior to [insert date that is 90 days after the notice date], you may elect to receive the portion of the settlement fund to which you are entitled or you may direct that it be paid to one of the charitable foundations listed on Exhibit A1 hereto.

By submitting a Claim Form, you are agreeing to be subject to the jurisdiction of the United States District Court for the Southern District of Florida for any proceedings relating to your Claim Form. Capitalized terms used in this Claim Form that are not otherwise defined herein have the meaning assigned to them in the Settlement Agreement.

Mail your completed Claim Form, with any required documentation, to the Settlement Administrator at the following address:

[insert contact information for the Settlement Administrator]

IF YOU ARE A MEMBER OF THE CLASS WHO HAS RETIRED FROM THE PRACTICE OF MEDICINE SUBSEQUENT TO AUGUST 4, 1990 OR ARE THE LEGAL HEIR OR REPRESENTATIVE OF A DECEASED CLASS MEMBER, PLEASE COMPLETE THIS PORTION OF THE FORM.

I certify that I have reviewed the enclosed notice of proposed settlement and that I am either a member of the class (as described in such notice of proposed settlement) who has retired from the practice of medicine subsequent to August 4, 1990 or that I am the legal heir or representative of a deceased member of the class. *If you are the legal heir or representative of a deceased member of the class, you must attach documentation to confirm your status.*

- By checking this box, I am directing the Settlement Administrator to pay to me my pro rata portion of the settlement fund that has been reserved for retired and deceased physicians.
- By checking this box, I am directing the Settlement Administrator to donate my pro rata portion of the settlement fund to the following charitable foundation, which I have selected from the list attached as Exhibit A1 hereto (select only one).

Name of Foundation: _____

Signature

Print Name

Date

Address

E-mail Address (optional)

Social Security Number

IF YOU ARE A MEMBER OF THE CLASS AND AN ACTIVE PRACTICING PHYSICIAN, PLEASE COMPLETE THIS PORTION OF THE FORM.

Members of the Class (as described in the enclosed notice of proposed settlement) who are active physicians are entitled to receive a pro rata amount of the portion of the settlement fund that is not reserved for retired or deceased physicians. Your settlement payment will be based upon the amount of payments received by you from WellPoint in payment for services during the three year period from 2002 to 2004 (or for any consecutive three-year period from January 1, 1996 through December 31, 2004 if you elect to submit payment records).

Active Physicians that received no payments from WellPoint, or payments from WellPoint of less than \$5,000, during the three year period from 2002 to 2004 will receive a settlement payment that is equal to the "base amount" of the settlement fund that is being paid to Active Physicians in the settlement.

Active Physicians that received payments from WellPoint of \$5,000 or more, and less than \$50,000, during the three year period from 2002 to 2004 will receive a settlement payment that is equal to five times the "base amount."

Active Physicians that received payments from WellPoint of \$50,000 or more during the three year period from 2002 to 2004 will receive a settlement payment that is equal to ten times the "base amount."

To simplify the process of obtaining payment from WellPoint, members of the class (as described in the enclosed notice of proposed settlement) who are Active Physicians may sign this claim form and submit it to the Settlement Administrator prior to **[insert date that is 90 days after the notice date]** without any additional documentation, in which event the amount of the settlement fund to which each such Active Physician is entitled to receive shall be determined based upon the Active Physician's certification as to the amount of WellPoint payments received from 2002 to 2004. Alternatively, Active Physicians may elect to submit to the Settlement Administrator proof of their payments from WellPoint, in the form of 1099 forms or other forms of proof, to show the amounts of payments received from WellPoint during any consecutive three-year period from January 1, 1996 through December 31, 2004 to justify the amount due to such Active Physician from the settlement fund. Active Physicians that have been paid through Physician Organizations or Physician Groups (including without limitation Delegated Entities) may submit to the Settlement Administrator proof of the amounts received during any consecutive three-year period from January 1, 1996 through December 31, 2004 for providing services to members of plans offered or administered by WellPoint.

Physician Groups and Physician Organizations may submit Claim Forms on behalf of physicians employed by or otherwise working with them without the necessity of individual signatures from the individual physician, if authorized to do so by such physicians.

Any questions about this procedure or proof that will be accepted should be addressed to the Settlement Administrator at:

[Insert contact information for Settlement Administrator]

I certify that I have reviewed the enclosed notice of proposed settlement and that I am a member of the Class (as described in the enclosed notice of proposed settlement) and am an actively-practicing physician.

For purposes of determining which box to check below, "WellPoint" means any of the present or former affiliates of WellPoint, Inc. or the former Anthem, Inc., that provided coverage to health benefit plan members. Please refer to the WellPoint affiliated companies listed in the enclosed notice of proposed settlement. In determining your gross receipts, you should include amounts paid by WellPoint directly or by intermediaries for providing covered services to WellPoint members. For example, you may have provided services to WellPoint members through an intermediary that contracted with WellPoint to provide the services, for example, an IPA, medical group, organized delivery system,

physician hospital organization, etc. In determining your gross receipts for providing covered services to WellPoint members, you should also include amounts you received from such intermediaries for treating WellPoint members.

Check ONLY ONE of the following FOUR boxes:

- By checking this box, I certify that I received no payments from WellPoint or that my gross receipts for providing covered services to WellPoint members during the three calendar year period of 2002, 2003 and 2004 were **less than \$5,000**.
- By checking this box, I certify that my gross receipts for providing covered services to WellPoint members during the three calendar year period of 2002, 2003 and 2004 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 WellPoint members during the three calendar year period of 2002, 2003 and 2004 were **\$50,000 or greater**.
- By checking this box, I certify that my gross receipts for providing covered services to WellPoint members during another consecutive three-year period since January 1, 1996 were in the amount shown below and are supported by the enclosed documents evidencing such receipts. Please fill in all three lines below and attach your proof or receipts:

3-Year Period: _____

Check one box to indicate your range of receipts for this 3-year period for providing covered services to WellPoint members:

- Under \$5,000 \$5,000-50,000 Over \$50,000

Description of Proof Attached: _____

All Active Physicians should also check one of the following two boxes:

- By checking this box, I am directing the Settlement Administrator to pay to me my pro rata portion of the settlement fund that has been reserved for Active Physicians.
- By checking this box, I am directing the Settlement Administrator to donate my pro rata portion of the settlement fund to the following charitable foundation, which I have selected from the list attached as Exhibit A1 hereto (select only one).

Name of Foundation: _____

Signature

Print Name

Date

Address

E-mail Address (optional)

WellPoint Provider Number (if applicable)

Social Security Number

Tax Identification Number

ALL CLAIMANTS MUST COMPLETE THIS SECTION

_____ Signature	_____ Print Name
_____ Address	_____ City, State Zip Code
_____/_____/_____ Date	_____ E-mail Address (optional)

SUBSTITUTE FORM W-9

On the appropriate line below, enter the Social Security Number or Employer Identification Number of the claimant whose name will appear on any claim check and related Form 1099. For individuals, this is your Social Security Number. For other entities, it is your Employer Identification Number (EIN). If you do not have a SSN or EIN, write "Applied For" on the appropriate line.

_____-_____-_____
Social Security Number **OR** ____-____-_____
Employer Identification Number

CERTIFICATION

I certify that the number shown on this form is my correct Social Security Number or Employer Identification Number (or I am waiting for a number to be issued to me) and the remaining information on this form is correct.

I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

The Internal Revenue Service does not require your consent to any provisions of this document other than the certifications required to avoid backup withholding.

Signature

_____/_____/_____
Date

Any Claim Form postmarked after [_____] is not a Valid Claim Form and will be denied by the Settlement Administrator.

IF YOU HAVE QUESTIONS ABOUT THE SETTLEMENT FUND, THE CHARITABLE FOUNDATIONS, OR ABOUT THE PROCEDURE FOR FILING A CLAIM FORM, CONTACT THE SETTLEMENT ADMINISTRATOR AT [_____] OR CLASS COUNSEL AT 1-866-809-8003.

DO NOT CONTACT THE COURT OR WELLPOINT WITH QUESTIONS ABOUT THE SETTLEMENT.

EXHIBIT A1

EXHIBIT A1

List of Charitable Foundations

National Foundations

1. Physicians' Foundation for Health Systems
2. Physicians' Foundation for Health Systems Innovations

State Foundations

3. Arlington County Medical Society Foundation
4. John P. Bowler, M.D., Memorial Library (New Hampshire Medical Society)
5. California Medical Association Foundation
6. CSMS Physicians' Health and Education Fund (Connecticut State Medical Society)
7. El Paso County Medical Society Foundation
8. Florida Medical Foundation (Florida Medical Association)
9. The Institute of Medicine and Public Health of New Jersey, Inc. (Medical Society of New Jersey)
10. Louisiana State Medical Society Educational and Research Foundation
11. Medical Association of Georgia Institute for Excellence in Medicine, Inc.
12. Medical, Educational and Scientific Foundation of New York, Inc. (Medical Society of the State of New York)
13. Medical Society of Northern Virginia Foundation
14. Nebraska Medical Foundation (Nebraska Medical Association)
15. North Carolina Medical Society Foundation, Inc.
16. South Carolina Medical Association Foundation
17. Tennessee Medical Foundation (Tennessee Medical Association)

18. Texas Medical Association Special Funds Foundation
19. Vermont Medical Society Education and Research Foundation, Inc.
20. Washington State Medical Education and Research Foundation (Washington State Medical Society)