MUST BE POSTMARKED ON OR BEFORE MAY 31, 2017

Superior Court of the State of California
County of San Diego

CIPRO CASES I & II
Judicial Council Coordination Proceedings Nos. 4154 and 4220

FOR OFFICIAL USE ONLY

CONSUMER PROOF OF CLAIM

YOUR CLAIM MUST BE POSTMARKED ON OR BEFORE MAY 31, 2017

Mail your claim to:

Cipro Settlement
c/o A.B. Data, Ltd
P.O. Box 173017
Milwaukee, WI 53217

OR

Submit the Proof of Claim form using the Claims Administrator's Website, www.CiproSettlement.com

Section A: Claimant Identification

Claimant's Name

Agent/Legal Representative

Street Address

City | State | Zip Code

Daytime Telephone Number | E-Mail Address

Section B: Should I File a Claim Form

Please answer the following question in order to determine if the Claimant is eligible for cash from the Proposed Settlement:

Did you pay a flat co-payment for Cipro and would you have paid the same co-payment for a generic substitute under the terms of your health insurance? ☐ **Yes** ☐ **No**

If you answered **Yes**, you are **NOT** eligible for cash from this Proposed Settlement.

If you answered **No**, you are eligible for cash from this Proposed Settlement. Please complete Section C.

Section C: Amount Claimed

Only complete either Part I or Part II or Part III below

Part I - Class Members who received a payment from the Cipro Bayer Settlement and did not submit additional purchase information in the HMR Settlement.
Please type or print in the box below, the total amount of the Class Member's out-of-pocket expenditures for purchases or reimbursement of Cipro® brand prescription ciprofloxacin in California between November 1, 2004 and December 31, 2005, inclusive.

Please attach claim documentation supporting your claim with this form (see Section D below).

CIPRO® BRAND PRESCRIPTION CIPROFLOXACIN	**TOTAL AMOUNT PAID**
Purchases or Reimbursements from November 1, 2004 to December 31, 2005, inclusive.	$

Part II - Class Members who DID NOT receive a payment from the Cipro Bayer Settlement, and did not submit additional purchase information with the HMR Settlement.
Please type or print in the box below, the total amount of the Class Member's out-of-pocket expenditures for purchases or reimbursement of Cipro® brand prescription ciprofloxacin in California between January 8, 1997 and December 31, 2005, inclusive.

Please attach claim documentation supporting your claim with this form (see Section D below).

CIPRO® BRAND PRESCRIPTION CIPROFLOXACIN	**TOTAL AMOUNT PAID**
Purchases or Reimbursements from January 8, 1997 to December 31, 2005, inclusive.	$

Part III - Class Members who submitted purchase information in the Bayer or HMR Settlements but have additional Cipro purchases between January 8, 1997 and December 31, 2005, inclusive.
Please type or print in the box below, the total amount of the Class Member's out-of-pocket expenditures for purchases or reimbursement of Cipro® brand prescription ciprofloxacin in California between January 8, 1997 and December 31, 2005, inclusive.

Please attach claim documentation supporting your claim with this form (see Section D below).

CIPRO® BRAND PRESCRIPTION CIPROFLOXACIN	**TOTAL AMOUNT PAID**
Purchases or Reimbursements from January 8, 1997 to December 31, 2005, inclusive.	$

Section D: Note Regarding Documentation

Any one of the following is acceptable as claim documentation for Cipro® brand prescription ciprofloxacin purchased or reimbursed between January 8, 1997 and December 31, 2005, inclusive:

1) Itemized receipts, cancelled checks, or credit card statement that shows a payment for Cipro; or
2) An EOB (explanation of benefits) from your insurer that shows you paid for Cipro; or
3) Records from your pharmacy showing that you paid for Cipro.

If you don't have documentation of the Class Member's Cipro purchases between January 8, 1997 and December 31, 2005, the claim may be capped at 80% of the amount claimed.

Please note the Claims Administrator may ask for additional proof of payment.

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 Proof of Claim 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 paid the total amount set forth above in out-of-pocket expenditures for purchases or reimbursements of Cipro® brand prescription ciprofloxacin in California during the period January 8, 1997 to December 31, 2005, inclusive. I further certify that I or the Class Member I represent did not opt out of the certified Class in these Actions, and did not obtain the Cipro indicated on the Proof of Claim form above through the MediCal Prescription Drug Program. Nor did I or the represented Class Member purchase such Cipro for purposes of resale. In addition, I have not (or the represented Class Member has not) served as an officer, director, agent, or employee of Hoechst Marion Roussel, Inc., Watson Pharmaceuticals, Inc., or The Rugby Group, Inc., or a corporate parent, subsidiary, affiliate, or other related entity thereof; or a judge or justice assigned to hear any aspect of this lawsuit.

To the extent I have been given authority to submit this Proof of Claim by a Class Member on its behalf, and accordingly am submitting this Proof of Claim 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. In the event 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 such amounts on its behalf, I and/or my employer will hold the Class, counsel for the Class, and the Settlement Administrator harmless with respect to any claims made by the Class Member.

I hereby submit to the jurisdiction of the Superior Court of the State of California, County of San Diego for all purposes connected with this Proof of Claim, including resolution of disputes relating to this Proof of Claim. 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 Proof of Claim by furnishing documentary backup for the information provided herein, upon request of the Settlement 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 Proof of Claim form was executed this _____ day of _____, 2017.

Signature	Print or Type Name

Mail the completed Claim Form postmarked on or before **May 31, 2017**, along with proof of payment, if required, to the following address:

Cipro Settlement
c/o A.B. Data, Ltd.
P.O. Box 173017
Milwaukee, WI 53217
Toll-Free Telephone: 1-866-404-0135 Website: www.CiproSettlement.com

REMINDER CHECKLIST:

1. Please complete and sign the above Proof of Claim form. Attach or upload any documentation supporting your claim.
2. Keep a copy of your Proof of Claim form and supporting documentation for your records.
3. If you would also like acknowledgement of receipt of your Proof of 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 Claims Administrator via the Settlement Website or U.S. Mail (the addresses are listed in the Notice).