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

THIRD-PARTY PAYOR PROOF OF CLAIM AND RELEASE

Use Blue or Black Ink Only

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT ON BEHALF OF A THIRD-PARTY PAYOR NOT INDIVIDUAL CONSUMERS

PART I – CLAIMANT IDENTIFICATION

SECTION A		SECTION B
ONLY IF YOU ARE FILING AS A CLASS MEMBER FOR YOUR COMPANY'S HEALTH PLAN	**OR**	ONLY IF YOU ARE AN AUTHORIZED AGENT FILING ON BEHALF OF ONE OR MORE CLASS MEMBERS

Section A: Company or Health Plan Class Member Only

Company or Health Plan Name

Contact Name

Mailing Address

Floor/Suite

City

State

Zip Code

Area Code - Telephone Number

Tax Identification Number

Email Address

List other names by which your company or health plan has been known or other Federal Employer Identification Numbers ("FEINs") it has used since January 8, 1997.

☐ Health Insurance Company/HMO ☐ Self-Insured Employee Health Plan ☐ Self-Insured Health & Welfare Fund

☐ Other (Explain)

Section B: Authorized Agent Only

** As an Authorized Agent, please check how your relationship with the Class Member(s) is best described:

☐ Third-Party Administrator

☐ Pharmacy Benefits Manager

☐ Other (Explain):

Authorized Agent's Firm Name

Contact Name

Street Address

City | State | Zip Code

Area Code - Telephone Number

Authorized Agent's Tax Identification Number

Email Address

Please list the name and FEIN of every Class Member (i.e., Company or Health Plan) for whom you have been duly authorized to submit this Claim Form (attach additional sheets to this Proof of Claim as necessary). Alternatively, you may submit the requested list of Class Member names and FEINs in an electronic format, such as Excel or a tab-delimited text file saved on a disk. Please contact the Claims Administrator to determine what formats are acceptable.

CLASS MEMBER'S NAME	CLASS MEMBER'S FEIN

PART II – AMOUNT CLAIMED

Only complete one Section below

Section A - Class Members that received a payment from the Cipro Bayer Settlement, but did not submit additional Cipro purchases for 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. This total amount equals the amount the Class Member paid or reimbursed minus any discounts, rebates, samples and reimbursements. Please attach or upload documents supporting your claim with this form.

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

Section B - Class Members that DID NOT receive a payment from the Cipro Bayer Settlement and did not submit a claim in the Cipro 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. This total amount equals the amount the Class Member paid or reimbursed minus any discounts, rebates, samples and reimbursements. Please attach or upload documents supporting your claim with this form.

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

If you are a third-party payor Class Member (such as an insurance company) and you don't have documentation of your Cipro purchases between January 8, 1997 and December 31, 2005, your claim (up to $300,000 in purchases) may be capped at 80% of the amount claimed. However, if you are claiming more than $300,000 in Cipro purchases between January 8, 1997 and December 31, 2005, you must submit claim documentation by attaching it, or your entire claim will be denied. Instructions on how to do so are found in the Claim Documentation Instructions on Page 2. If your total net claim is $300,000 or less, you need not provide complete claims data with this Claim Form, but the Claims Administrator may require supporting documentation.

PART III – CERTIFICATION

I (We) have read and am (are) familiar with the contents of the Instructions accompanying this Claim Form. I (We) certify that the information I (we) have set forth in the above Proof of Claim and in any documents attached by me (us) are true, correct and complete to the best of my (our) knowledge. I (We) certify that I (we) of the Class Member(s) I (we) 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 (We) further certify that I (we) or the Class Member(s) I (we) 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 (we) of the represented Class Member(s) purchase such Cipro for purposes of resale. In addition, I (we) have not (or the represented Class Member(s) has not) served as an officer, director, agent, of 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 of justice assigned to hear any aspect of this lawsuit.

To the extent I (we) have been given authority to submit this Proof of Claim by a Class Member(s) 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(s) identified on a separate sheet of paper submitted with this form, and to the extent I (we) have been authorized to receive on behalf of this Class Member(s). In the event amounts from the Settlement Fund are distributed to me (us) and a Class Member(s) later claims that I (we) did not have authority to claim and/or receive such amounts on its behalf, I (we) and/or my (our) employer will hold the Class, counsel for the Class, and the Settlement Administrator harmless with respect to any claims made by the Class Member(s).

I (We) hereby submit to the jurisdiction of the Superior Court of the State of California, County of San Diego for all purposes connected with the Proof of Claim, including resolution of disputes relating to this Proof of Claim. I(we) acknowledge that any false information or representations contained herein may subject me (us) to sanctions, including the possibility of criminal prosecution.

I (we) agree to supplement this Proof of Claim by furnishing documentary backup for the information provided herein, upon request of the Settlement 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	Position/Title
Print Name	**Date**

Mail the completed Claim Form, along with any supporting documentation as described in Claim Documentation Instructions on page 2 above, postmarked on or before **MAY 31, 2017** to:

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).