SUPERIOR COURT OF CALIFORNIA
COUNTY OF SAN DIEGO

IN RE: CIPRO CASES I & II	Judicial Council Coordination Proceeding Nos. 4154 & 4220

INSTRUCTIONS FOR SUBMITTING YOUR PROOF OF CLAIM

In order to qualify to receive a payment from this Settlement in *Cipro Cases I II*, as described in the Notice of Settlement, you must file the attached Proof of Claim form either on paper or electronically on the Settlement website, and you may need to provide certain requested documentation to substantiate your claim.

This is the third settlement covering purchases of Cipro made in California.

1. If you did not file a Claim Form in either the Bayer or HMR Settlements, you need to file a Claim Form in this Barr Settlement to receive payment.
2. If you previously filed a Claim Form in the HMR Settlement for purchases between January 8, 1997 and December 31, 2005, you do not need to do anything to receive the payment from the Barr Settlement unless you have additional purchase information to provide.
3. If you previously filed a Claim Form in the Bayer Settlement for purchases between January 8, 1997 and October 31, 2004, and you did not provide additional information in the HMR Settlement for purchases from November 1, 2004 through December 31, 2005, please provide additional purchase information for November 1, 2004 through December 31, 2005.

REQUIREMENTS FOR FILING THE ATTACHED PROOF OF CLAIM FORM

Your Claim will be considered only if you meet the following conditions:

1. If you are a Class member (*i.e.*, health insurance company/HMO, self insured employee health plan, self-insured union health & welfare fund, etc.), you must accurately complete all required portions of the attached Proof of Claim form in "***Part I, Section A - COMPANY OR HEALTH PLAN CLASS MEMBER ONLY***," in addition to the other information requested by this Claim Form.
2. You must sign the Proof of Claim form, which includes the Certification. If you submit the form electronically, your electronic signature and submission of the form will have the same force and effect as if you signed the form on paper.
3. By signing and submitting the Proof of Claim form, you are swearing under penalty of perjury that you paid or reimbursed for the Cipro® brand prescription ciprofloxacin purchased in the State of California listed on the Claim Form, and that you did not resell the Cipro.
4. If you are an Authorized Agent of one or more Class Members, you must provide the information requested in ***Part 1, Section B - "AUTHORIZED AGENT ONLY,"*** in addition to the other information requested by this Claim Form, as well as providing the capacity in which you are submitting the claim and proof of your authority to do so.

   In addition, if you are the Authorized Agent of a third-party payor such as a health insurance company, by signing and submitting the Proof of Claim form you certify that the Cipro for which that third-party payor paid or reimbursed was intended for consumption by or for your members, participants, employees or insureds.
5. You have two options for completing a Proof of Claim form:
   a. You can mail the completed and **signed** Proof of Claim for and Certification by First-Class U.S. Mail, postage prepaid, postmarked no later than May 31, 2017, to:

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

OR

b. You can complete and submit the Proof of Claim form and Certification using the Claims Administrator's Settlement Website, www.CiproSettlement.com. Upon completion of the online Proof of Claim form, you will receive an acknowledgement that your claim has been submitted. If you choose this option and file a claim electronically, your electronic signature and submission of the form will conform to the requirements of the Electronic Signatures Act, 15 U.S.C. § 7001, *et seq*., and will have the same force and effect as if you signed the Proof of Claim form in hard copy.

6. Your failure to complete and submit the Proof of Claim form postmarked or filed online by **May 31, 2017**, will prevent you from receiving any payment from this Settlement. Submission of this Proof of Claim form does not assure that you will share in the payments related to *Cipro Cases I II*. If the Claim Administrator disputes a material fact concerning your Claim, you will have the right to present information in a dispute resolution process. For more information on this process, visit www.CiproSettlement.com.

CLAIM DOCUMENTATION INSTRUCTIONS

You must provide all the information requested in Part II of the Claim Form. If you are claiming more than $300,000 in net purchase amounts, you must also provide data and information sufficient to show the total purchase amounts of Cipro that you are claiming. Your claimed purchase amounts of Cipro must be net of co-pays, deductibles, and co-insurance.

It is mandatory that you provide the data for **all** categories listed below.

a. **Unique patient identification number or code**
b. **NDC Number (a list of NDC Numbers is included with this Claim Form)** -- e.g., 00000-0000-00
c. **Fill Date or Date of Service** -- e.g., 01/01/2007
d. **Location (State) of Service** -- e.g., CA
e. **Amount Billed (not including dispensing fee)** -- e.g., 40.00
f. **Amount Paid by TPP net of co-pays, deductibles, and co-insurance** -- e.g., 20.00

If you are submitting a Claim Form on behalf of multiple Class members, also provide the following information for each prescription:

g. **Plan or Group Name**
h. **Plan or Group FEIN** -- provide group number for each transaction

For your convenience, an exemplar spreadsheet containing these categories is attached at the end of this Claim Form. In addition, an Excel spreadsheet can be downloaded from the Settlement website, www.CiproSettlement.com. Please use this format if possible. A list of the NDCs that will be considered by the Claims Administrator is provided following the exemplar spreadsheet.

If possible, please provide the electronic data in either Microsoft Excel format of ASCII flat file pipe "|" or tab delimited or fixed-width format.

Please contact the Claims Administrator at 1-866-404-0135 with any questions about the required claims data.

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).