

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
Miami Division

MDL NO.: 1334
MASTER FILE NO.: 00-1334-MD-MORENO

IN RE:
MANAGED CARE LITIGATION

THIS DOCUMENT RELATES TO
PROVIDER TRACK CASES ONLY

PROOF OF CLAIM FORM

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

If you would like for the portion of the settlement fund that you are entitled to receive to be donated to a charitable foundation that has been established in connection with the settlement of the class action and that will be dedicated to promoting high quality healthcare and will give particular emphasis to initiatives that assist physicians to improve/enhance the quality of care received by patients, you do not need to do anything with respect to this form. All settlement funds that are not paid to members of the class will be donated to this charitable foundation.

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.

- 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 charitable foundation.

If you do not submit this form to the settlement administrator prior to [insert date that is 90 days after the notice date], the portion of the settlement fund that you are entitled to receive will be donated to a charitable foundation that has been established in connection with the settlement of the class action and that will be dedicated to promoting high quality healthcare and will give particular emphasis to initiatives that assist physicians to improve/enhance the quality of care received by patients, you do not need to do anything with respect to this form. 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 this charitable foundation.

Signature

Print Name

Address

Social Security Number

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

Members of the class (as described in the enclosed notice of proposed settlement) who are actively-practicing 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 Aetna in payment for services during any consecutive three-year period from 1990 through 2002.

Active physicians that received no payments from Aetna, or payments from Aetna of less than \$5,000, in any such consecutive three-year period 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 Aetna of \$5,000 or more, and less than \$50,000, in any such consecutive three-year period will receive a settlement payment that is equal to twice the "base amount".

Active physicians that received payments from Aetna of \$50,000 or more in any such consecutive three-year period will receive a settlement payment that is equal to three times the "base amount".

To simplify the process of obtaining payment from Aetna, members of the class (as described in the enclosed notice of proposed settlement) who are actively-practicing 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 on Aetna's books and records for the period beginning from 2000 through the end of 2002. Alternatively, active physicians may elect to submit to the settlement administrator proof of their payments from Aetna, in the form of 1099 forms or other forms of proof, to show the amounts of payments received from Aetna during any three consecutive years from 1990 through 2002 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 in any three consecutive years from 1990 through 2002 for providing services to members of plans offered or administered by Aetna or its predecessors.

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

[insert appropriate 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.

- By checking this box, I am directing the settlement administrator to pay to me the amount of the settlement fund to which I am entitled, based on Aetna's books and records.
- By checking this box, I am directing the settlement administrator to donate the amount of the settlement fund to which I am entitled to the charitable foundation.
- By checking this box, I am directing the settlement administrator to determine the amount of the settlement fund to which I am entitled based on the enclosed proof of payments that I received from Aetna, or for serving members of plans offered or administered by Aetna, for any

three consecutive years from 1990 through 2002. I certify that the amount of such enclosed proof of payments is \$_____.

*If you do not submit this form to the settlement administrator prior to [insert date that is 90 days after the notice date], the portion of the settlement fund that you are entitled to receive will be donated to a charitable foundation that has been established in connection with the settlement of the class action and that will be dedicated to promoting high quality healthcare and will give particular emphasis to initiatives that assist physicians to improve/enhance the quality of care received by patients, you do not need to do anything with respect to this form. 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 this charitable foundation.*

Signature

Print Name

Address

Social Security Number