

EXHIBIT 3B

CLAIM FORM FOR CAPITAL BLUE PLAN'S SETTLEMENT FUND

You must read the Notice of Proposed Settlement and Claim Form Instructions before completing this Claim Form. The capitalized terms used in this Claim Form are defined in the Settlement Agreement. The **settling Blue Plan** consists of **Capital BlueCross, Capital Advantage Insurance Company and Keystone Health Plan Central**. A Class Member may file only one Claim Form.

SECTION A: CLAIMANT INFORMATION

Check Only One (YOU MAY MAKE A CLAIM EITHER THROUGH A PHYSICIAN GROUP/ORGANIZATION OR INDIVIDUALLY, BUT NOT BOTH):

Physician Group/Organization Please indicate the number of Physicians on your rider/list _____

<i>Physician Group or Organization Name</i>	
<i>Name and Title of Employee/Representative Filing</i>	<i>Phone</i>

Physician Groups/Organizations must attach a list of Physicians for whom they are submitting claims, along with the information specified in the Claim Form Instructions enclosed with this mailing, for each Physician for whom the Physician Group/Organization is submitting a Claim. This information must be set forth on the rider attached to this Claim Form, or, alternatively, on a substantially similar form.

Individual Physician Please indicate your Physician type (e.g., MD or DO) _____

<i>Name of Physician</i>	
<i>Name of Representative (If Physician is Deceased*)</i>	<i>Phone</i>

*If you are the legal heir or representative of a deceased Class Member, you must attach documentation such as a death certificate or letters of administration for an estate to confirm your status. The Tax I.D. requested in Section E is that of the heir or estate.

Mailing Address

<i>Mailing Address (Street, PO Box, Suite or Office Number, as applicable)</i>			
<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Blue Cross/Blue Shield Provider Number (if applicable)</i>

SECTION B: INFORMATION ON SERVICES PROVIDED TO PLAN MEMBER OF SETTLING BLUE PLAN

Individual Claimants: please check ONLY ONE of the boxes below.

- I. By checking this box, I certify that I have provided services to Plan Members of the settling Blue Plan.
- II. By checking this box, I certify that I have NOT provided services to Plan Members of the settling Blue Plan.

Physician Groups and Physician Organizations: please attach a list that designates the proper category for each Physician for whom you are filing this claim (by using the attached rider, or alternatively, a substantially similar form).

SECTION C: SUBSTITUTE W-9

On the appropriate line, enter the Social Security Number or Employer Identification Number of the claimant whose name will appear on any check and related Form-1099. For individuals, this is your Social Security Number (SSN). For Physician Groups and Physician Organizations, this is your Employer Identification Number (EIN).

Social Security Number (SSN) OR _____
Employer Identification Number (EIN)

By signing this Claim Form, I certify that:

1. The number shown on this form above is the correct Social Security Number or Employer Identification Number for this claimant; and
2. The claimant is not subject to backup withholding because the claimant: (a) is exempt from backup withholding, or (b) has not been notified by the Internal Revenue Service (IRS) that the claimant is subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified the claimant that the claimant is no longer subject to backup withholding.

NOTE: Backup withholding is extra tax withholding that occurs when a taxpayer has underreported interest or dividends in a previous year. The IRS notifies taxpayers who are subject to backup withholding. If you (the claimant) have been notified by the IRS that you are subject to backup withholding because you have failed to report all interest and dividends on your tax return, you must cross out item 2 above by placing a line through the section. The IRS does not require your consent to any provision of this document other than the certifications above required to avoid backup withholding.

SECTION D: CERTIFICATION

I do declare and certify, under penalties of perjury, as follows:

- I am a Class Member, a legal heir or representative of a deceased Class Member, or an authorized representative of the Physician Group or Physician Organization identified above;
- I am not submitting a claim on behalf of any Class Members who have submitted a request to Opt Out of the Class and Settlement;
- I am not submitting a claim on behalf of any Physicians who are, on their own behalf, submitting separate claims;
- All of the statements and information provided in this Claim Form are true, correct and complete, to the best of my knowledge.

Signature Date

This Claim Form should be sent to the Settlement Administrator at:

[ADDRESS]

YOU MUST COMPLETE AND SIGN THIS CLAIM FORM, AND THE ENVELOPE RETURNING YOUR CLAIM FORM MUST BE MAILED TO THE SETTLEMENT ADMINISTRATOR WITH A POSTMARK DATE NO LATER THAN 90 DAYS AFTER NOTICE DATE.

IF YOUR SIGNED CLAIM FORM IS NOT MAILED TO THE SETTLEMENT ADMINISTRATOR BY THIS DEADLINE, YOU WILL BE DEEMED TO HAVE WAIVED YOUR RIGHT TO RECEIVE ANY PAYMENT FROM THE SETTLEMENT FUND.

WE STRONGLY RECOMMEND SENDING YOUR CLAIM FORM VIA REGISTERED OR CERTIFIED MAIL AND RETAINING YOUR RECEIPT AND A COPY OF YOUR CLAIM FORM FOR YOUR RECORDS.

If you have any questions, please call the Settlement Administrator at [PHONE]

