

EXHIBIT 3D

**INSTRUCTIONS REGARDING THE CLAIM FORM FOR  
THE CAPITAL BLUE PLAN'S SETTLEMENT FUND**

**It is very important that you read the enclosed Notice of Proposed Settlement  
in order to fully understand your rights under this Settlement.**

**The settling Blue Plan consists of CAPITAL BLUECROSS, CAPITAL ADVANTAGE INSURANCE  
COMPANY AND KEYSTONE HEALTH PLAN CENTRAL.**

**DEADLINE FOR CLAIM FORM SUBMISSION: Postmarked by \_\_\_\_\_**

**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.**

A Class Member may file only one Claim Form.

By submitting a Claim Form you are agreeing to be subject to the jurisdiction of the United States District Court for the Southern District of Florida for any proceedings relating to your Claim or Claim Form. Capitalized terms used in the Instructions and Claim Form that are not otherwise defined herein are defined in the Settlement Agreement. A copy of the Settlement Agreement can be found on:

[Settlement Administrator's website] [www.hmosettlements.com](http://www.hmosettlements.com); [www.WhatlevDrake.com](http://www.WhatlevDrake.com); [www.ArchieLamb.com](http://www.ArchieLamb.com); and [www.kttlaw.com](http://www.kttlaw.com)

The "Class" is defined in the Settlement Agreement and described in the enclosed Notice of Proposed Settlement.

Mail your completed Claim Form to the Settlement Administrator at:

**Settlement Administrator** \_\_\_\_\_

**SECTION-BY-SECTION INSTRUCTIONS:**

**Section A: ALL CLAIMANTS MUST COMPLETE THIS SECTION.**

**PHYSICIAN GROUPS OR ORGANIZATIONS: If you are representing a Physician Group or Physician Organization, in Section A, please write in the Group or Organization name, the name of the person completing the Claim Form, and attach a list of all the Physicians for whom you are filing this Claim. Physician Groups and Physician Organizations may submit Claim Forms on behalf of Physicians employed by or working with them without providing individual signatures from the individual Physicians, if authorized to do so by the individual Physicians and if the individual Physicians do not also submit Claim Forms on their own behalf and do not request to Opt Out. Your list of Physicians should be set forth on the rider attached to the Claim Form, or on a substantially similar document, and must include all of the following information for each Physician:**

1. Physician name
2. Physician Type (example: MD or DO)
3. Last four digits of each Physician's Social Security Number (SSN)
4. Whether Physician has provided services to Plan Members of the settling Blue Plan

**Section B: ALL CLAIMANTS (GROUPS AND INDIVIDUALS) MUST COMPLETE THIS SECTION.**

**Section C: ALL CLAIMANTS (GROUPS AND INDIVIDUALS) MUST COMPLETE THIS SECTION.**

**Section D: ALL CLAIMANTS (GROUPS AND INDIVIDUALS) MUST COMPLETE THIS SECTION.**

IF YOU HAVE QUESTIONS ABOUT THE SETTLEMENT FUND OR ABOUT THE PROCEDURE FOR FILING A CLAIM FORM, CONTACT THE SETTLEMENT ADMINISTRATOR AT OR CLASS COUNSEL AT \_\_\_\_\_

**DO NOT CONTACT THE COURT OR BLUE PLAN WITH QUESTIONS ABOUT THE SETTLEMENT.**