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In re: Lincare Holdings, Inc. Data Breach Litigation
Case No. 8:22-cv-1472-TPB-AAS (M.D. Fla.)

CLAIM FORM

ATTENTION: This Claim Form[1] is to be used to apply for benefits from the Settlement with Lincare Holdings, Inc. ("Defendant") of claims related to the alleged unauthorized disclosure of personally identifiable information and protected health information (together "PII") that occurred on or about September 2021, when Defendant experienced an intrusion into its system by an external individual (the "Incident"). To recover as part of this Settlement, you *must* provide the information requested in this Claim Form for each applicable Claim. PLEASE BE ADVISED that any documentation you provide, as detailed below, must be submitted with this Claim Form to be considered.

This Claim Form should be used to make Claims for the following benefits under the Settlement Agreement: (1) Identity theft protection and medical information monitoring through Medical Shield, (2) Payment for Out-of-Pocket Losses fairly traceable to the Incident, (3) Payment for attested Lost Time spent remedying issues related to the Incident, (4) Payment for certain statutory claims by Settlement Class Members who were residents of California at the time of the Incident. For further information on each, please see the Notice you have received or visit **www.LincareSettlement.com**.

All Claims should be filed online with the Claims Administrator or mailed to Lincare Holdings Inc. Class Action, c/o Kroll Settlement Administration LLC, PO Box 225391, New York, NY 10150-5391, and must be postmarked by **April 15, 2024**.

Settlement Class Member & Claimant Information

_____ ____ _____
First Name MI Last Name

_____
Mailing Address (Street, PO Box, Suite or Office Number, as applicable)

_____ _____ _____ _____ _____ _____ _____ _____ _____
City State Zip Code

(_____ _____ _____) _____ _____ _____ - _____ _____ _____ _____
Telephone Number (including Area Code)

_____@_____
Email Address

To make a Settlement Claim under any of the Claims categories specified below, you must first affirm the following:

☐ I affirm that I have provided my PII to Defendant, or one of its subsidiaries or affiliated companies, and that my PII was potentially disclosed, compromised, or accessed by a third party as a result of a cyber-breach or data incident experienced by Defendant in September 2021.

-OR-

☐ I affirm that I was sent a notification letter or email from Defendant between November 2021 and October 2022, informing me that an intrusion into Defendant's systems on or about September 2021, may have resulted in the dissemination of documents containing my PII.

[1] Note that any capitalized terms not defined herein shall have the meanings ascribed to them in the Settlement Agreement, which is available at **www.LincareSettlement.com**. Additionally, to the extent there are any conflicts or inconsistencies between this form and the Settlement Agreement, the terms of the Settlement Agreement shall govern.

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If you can affirm one of the foregoing, you may submit a Settlement Claim under any or all of the Claims categories specified below that you qualify for:

Claim Category A: Identity Theft Protection and Medical Information Monitoring Services

You are eligible to enroll in 12 months of free Medical Shield Monitoring services. Do you wish to enroll?

☐ Yes, I elect to receive Medical Shield Services enrollment instructions commencing within thirty (30) days of the Effective Date of the Settlement. Please send me enrollment instructions to the following email address or physical address:

Email Address:_____@_____

Physical Address: _____

Mailing Address (Street, PO Box, Suite or Office Number, as applicable)

_____ _____ _____ _____ _____ _____

City State Zip Code

☐ No, I elect to not receive Medical Shield Monitoring services under the Settlement.

Claim Category B: Out-of-Pocket Losses

☐ I affirm that I incurred Out-of-Pocket Losses fairly traceable to the Incident, which have not been reimbursed, and were incurred between September 10, 2021, and the date I received Notice of the Settlement.

-AND-

☐ I affirm that I have documentation of my Out-of-Locket Losses referenced in the preceding paragraph, and I have submitted such documentation with this Claim Form.

-AND-

☐ I affirm that the information that I provide in the following table is accurate to the best of my knowledge.

Loss Type	Date(s) of Loss	Amount You Actually Paid	Description of Supporting Documents (Identify what you are attaching and why)
***I had unreimbursed expenses because of the Incident for*:**			
Description of cost and explanation of how the Incident caused the cost to be incurred		$	
		$	
		$	

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Claim Category C: Lost Time

☐ I affirm that I spent time dealing with the effects or perceived effects of the Incident, and I am submitting a statement, signed under the penalty of perjury, providing a detailed explanation of the activities related to the Incident on which my time was spent, and stating the amount of time (up to 4 hours) that I spent dealing with the effects of the Incident.

Time Spent: _____ (maximum of 4 hours) **x** $20/hour = $ _____ . _____ _____

Out-of-Pocket Losses Claimed (Claim Category B) + Lost Time Claimed (Claim Category C) = $ _____. ____ ____ (maximum of $5,000)

You may submit up to a total of $5,000 for combined Out-of-Pocket Losses and Lost Time. The final amount reimbursed will be determined once all valid claims have been accounted for.

Failure to affirm or provide appropriate documentation will result in the denial of your claim under this category.

Claim Category D: California Claims

☐ I affirm, under penalty of perjury, that I was a resident of California during the time of the Incident (i.e., September 2021), and I would like to Claim up to $90 as an additional benefit.

CERTIFICATION

I understand that my Claim(s) contained in this Claim Form, based on the information provided above and the documentation submitted with this Claim From, will be subject to verification.

By submitting this Claim Form, I hereby also declare under penalty of perjury under the law of the United States of America that the information provided in this Claim Form and in any documentation I drafted and submitted with this Claim Form is true and correct. I further certify that any documentation that I have submitted in support of my Claim(s) on this Claim Form consists of unaltered documents in my possession.

☐ **Yes, I understand that I am submitting this Claim Form and the affirmations it makes under the penalty of perjury. I further understand that my failure to check this box may render my Claim null and void.**

Claimant Signature: _____ Date: ____ ____ / ____ ____ / ____ ____ ____ ____

Printed Name: _____