SUPERIOR COURT OF THE STATE OF CALIFORNIA, COUNTY OF SACRAMENTO
Sharon Marie Shurtleff v. Health Net of California, Inc.
No. 34-2012-00121600

REIMBURSEMENT OF IDENTITY THEFT LOSSES CLAIM FORM

Eligible Class Members are entitled to recover reimbursement of actual, documented and unreimbursed "identity theft" losses. "Identity theft" is defined as "the use of a Settlement Class Member's name, address, Social Security number (SSN), bank, or credit card account number, or other identifying information without the Settlement Class Member's knowledge to commit fraud or other crimes." The losses incurred must have occurred during the time period from January 21, 2011 through and including April 21, 2014 (the "Claims Period"). Losses exclude any charges initiated with the Settlement Class Member's authorization and any losses covered by identity theft or other insurance. Additional information is contained in the Detailed Notice and the Settlement Agreement, both of which are available at www.HealthNetDataSettlement.com or by calling 1-800-391-2729.

To receive reimbursement of your identity theft losses you must: (1) provide all information required below, (2) submit all documentation that supports your claim of theft (such as receipts, correspondence, police reports, stolen property reports, insurance claims, bank statements, etc.), and (3) submit this form with your supporting documentation to the following address:

Health Net Data Settlement Administrator
P.O. Box 43204
Providence, RI 02940-3204

If you have any questions, call 1-800-391-2729 to speak with a representative or go to www.HealthNetDataSettlement.com for more information.

Deadlines: The deadline to submit a claim is **April 21, 2014**.

Questions? Call 1-800-391-2729 or visit www.HealthNetDataSettlement.com

CLAIMANT INFORMATION ***Please Type or Print in the Boxes Below; Do NOT use Red Ink, Pencil, or Staples***

First Name | MI | Last Name

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

City | State | Zip Code

ADDITIONAL INFORMATION

Social Security Number

Email Address (optional)

(Username) @ (Domain name)

Telephone Number (optional)

By filling in the information herein and requesting reimbursement of an identity theft loss(es), you are certifying that such loss (1) is an actual, documented and unreimbursed loss, (2) that such loss occurred during the time period from January 21, 2011, through and including April 21, 2014, and (3) that before your discovery of such loss, you did not receive written notice of any other data breach involving your individually identifiable personal, medical, and/or financial information. You are also agreeing reasonably to cooperate with any investigation by Health Net of your claim. If you accepted Health Net's prior offer of identity theft insurance, or obtained such insurance at your own expense, and the loss occurred during the coverage period of such insurance, you may file a claim for reimbursement only if your insurance policy denied coverage for such loss.

You may request a total of up to $50,000. Only one (1) form is needed for multiple losses incurred from the same incident. If you are claiming losses from more than one incident of identity theft, please complete a separate claim form for each.

Amount requested:

$, .

Documentary proof must be submitted to support your claim amount.

Please provide a brief description of the fraud or identity theft you are experiencing or have experienced. (You may attach additional pages if necessary.)

SIGNATURE & CERTIFICATION

I hereby declare under penalty of perjury that the information I am providing in support of my claim is true and correct. I further certify that any documentation that I have submitted in support of my claim consists of unaltered documents in my possession.

Signature: _____ Date (mm/dd/yyyy): _____

Print Name: _____

Mail your claim to:

Health Net Data Settlement Administrator
P.O. Box 43204
Providence, RI 02940-3204

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