CLAIM FORM INSTRUCTIONS

You must complete and return a claim form if you wish to be reimbursed for out-of-pocket payments or debt owed for the cost of Applied Behavioral Analysis ("ABA") therapy to treat an autism spectrum disorder ("Autism") incurred between January 1, 2010 and December 31, 2014 under the terms of the Settlement Agreement. You must complete both the front and back of the claim form.

All claims must be *<u>received</u>* by the Claims Administrator by no later than December 22, 2016. Any claims received after this date will not be eligible for payment.

A. Front and Back of Claim Form Must Be Completed.

For each date of ABA therapy, you must identify, on the Claim Form: (1) the date of service (month/year); (2) the name of the provider on that date and each provider's address and phone number, if available; (3) a short description of the service; and (4) the amount paid or debt owed related to the service.

You must also sign the back of the form and certify that the information you have provided is true and correct under penalty of perjury.

B. Documentation.

In addition to the Claim Form, you must verify that the person who received the ABA therapy had a DSM diagnosis for Autism (including the name of the provider who made the diagnosis and the date of diagnosis and address and phone number, if available), and submit proof of ABA therapy dates and provider, and proof of payment or obligation to pay.

1. Proof of ABA therapy dates can be evidenced by clinical notes, an appointment schedule/log created at the time of treatment, invoices seeking payment that include dates of service, or other evidence of similar reliability.
2. The identity of the provider of ABA therapy can be evidenced by identification on clinical notes, appointment schedule/logs, invoices, or other documents of similar reliability.
3. Proof of payment or debt owed may consist of: cancelled checks, credit card account statements, provider ledgers, invoices stamped "paid" or showing amounts due, checking account statements, signed letters from the provider or provider's employer documenting the amount paid or debt incurred (so long as the letter clearly connects payments or debt with specific ABA therapy dates), or other evidence of similar reliability and containing similar specificity connecting payments/debt to the ABA therapy date(s). You must include this additional proof with your Claim Form.

C. All Claims Submitted in One Mailing.

All claims should be submitted in a single mailing. You may obtain additional copies of Claim Forms or make copies of the form yourself. Documents that you submit will not be returned, so please do not send original documents and you may wish to keep a copy of your submission for your records.

D. Mail Your Claim Form.

Your Claim Form should be mailed to:

T-Mobile ABA Claims Processing
1700 7th Avenue, Suite 116 #330
Seattle, WA 98101

You may not submit Claim Forms by telephone, fax, e-mail or other means. If you want verification that your Claim Form was received, then you must mail your Claim Form via registered or certified mail.

Your claim form with attached documentation must be **received** by December 22, 2016. Please mail the form with sufficient time for delivery.

E. Investigation.

The Claims Administrator, T-Mobile USA, Inc. Employee Benefit Plan, Defendants, and/or Class Counsel may independently confirm any claim. By submitting a Claim Form you agree that such an investigation may be made. The failure to cooperate may be grounds to deny a claim.

F. Payment of Claims.

After you submit your claim, the Claims Processor will process the claim and determine whether you may be paid out of the settlement funds. Payment is contingent upon final Court approval of the proposed Agreement. This process will take several months.

If your claim is approved by the Claims Processor and authorized by the Court, you will be mailed a check for the approved amount of the claim. If your claim is denied, in whole or in part, the Claims Processor will provide a letter of explanation. That letter will explain why your claim was denied. You will be given an opportunity to correct any problems. If you disagree with the Claims Processor's determination, then you may follow the steps set forth in the denial letter to appeal.

Questions?

If you have questions about how to complete this Claim Form, you may contact Class Counsel, Sirianni Youtz Spoonemore Hamburger, at (206) 838-3210.

A.D., et al. v. T-Mobile USA, Inc. Employee Benefit Plan, et al.
Applied Behavioral Analysis Therapy Qualified Settlement Fund

CERTIFICATION OF PAYMENT(S)

I hereby certify that I (or my dependents) incurred out-of-pocket expenses, or debt, for Applied Behavioral Analysis ("ABA") therapy as set forth on the claim form on the back of this page and any additional pages I have attached. I further certify that the information provided in this Claim Form is true and correct under penalty of perjury under the laws of the United States.

Signature: ____ Date: ______________________

* * *

Type or Print Your Name (required): ____

Name of Person who received ABA therapy (required):____

DSM Diagnosis of Person who received ABA therapy (required): ________________________________

Diagnosis made by: ____(Name of provider required)

Date of Diagnosis: ____ (Date of original diagnosis required)

You **must** include the following elements of proof with this claim form: (1) proof of ABA therapy dates; (2) identity of the ABA therapy provider; and (3) the unreimbursed charges or debt incurred. You are also requested, but not required, to provide the address and/or phone number of the provider(s), as this may help expedite payment to you. Please see the enclosed "Instructions for Claim Form" material under "Documentation" for a list of the type of documents that must be submitted to establish each element.

Current Address: ____
(Street or P.O. Box)

____
City, State and Zip Code

Daytime/Evening
Telephone Numbers: ______________________________ (day) ______________________________ (eve.)

Email Address: ____

If you received this notice in the mail, then please write your identification number (from the address label on the envelope) here: ____________________________________

CLAIM FOR FOR ____

Please print your name

NOTE: If you need additional pages for more claims, you may either make a copy of this blank claim form or obtain additional forms from www.sylaw.com/T-MobileSettlement. You must also fill out the back side of this form to be eligible for reimbursement.

Date of Service (at least month and year) (Required)	**Provider Name** (and address and phone number, if available) (Required)	**Description of Service** (including frequency and duration) (Required)	**Diagnosis of Condition Treated*** (Required)	**Amount You Paid or Owe for the Service** (Required)

Please attach all documents that show that you received and incurred a debt for the services identified above, such as itemized statements, cancelled checks, credit card statements, receipts, treatment summaries, etc.

DO NOT SEND ORIGINALS AS THEY WILL NOT BE RETURNED TO YOU.

* If you do not know the diagnosis given by your provider, please contact your provider to obtain the diagnosis of the condition for which you received treatment.