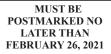
<<Barcode>>

Class Member ID: <<Refnum>>



PROOF OF CLAIM FORM

RE: Rolan v. New West Health Services, et al., 6-15-cv-0051

FOR OFFICE USE ONLY	

IMPORTANT: A CLAIM FORM MUST BE SUBMITTED ON OR BEFORE FEBRUARY 26, 2021 AND MAILED TO THE FOLLOWING ADDRESS:

New West Health Services Settlement Administrator

Heffler Claims Group

P.O. Box 8769

Philadelphia, PA 19101-8769

Firstname:	MI	For your Claim Form to be valid, your form must be signed, dated and submitted to the Settlement Administrator at the address
Last Name:		listed above.
Street Address:		
City:		SIGNATURE:
State: Zip Code:		
Phone Number: ()	-	Dated: / /
Email Address:@		