<<Barcode>>

Class Member ID: <<Refnum>>

MUST BE POSTMARKED NO LATER THAN FEBRUARY 26, 2021

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 _____

Last Name: _____

Street Address: _____

City: _____

State: _____ _____ Zip Code: ___ ___ ___ ___ ___ - ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Email Address: _____@_____

For your Claim Form to be valid, your form must be signed, dated and submitted to the Settlement Administrator at the address listed above.

_____

SIGNATURE:

Dated: ___ ___ / ___ ___ / ___ ___ ___ ___