Resurrection Health Care Settlement Administrator
P.O. Box 56798
Jacksonville, FL 32241-6798

Uninsured Patient Claim Form

The Court has preliminarily approved a class action settlement that may entitle you to a refund, a voucher or a recalculation of an existing medical bill that you have received from a Resurrection Hospital. In order to process your claim, you must fill out this form.

Please follow the instructions carefully. Instructions on Reverse.

STEP 1: Determine Eligibility

Note: To be eligible, you must answer "True" "False" or "Unsure" to each of the following

True	False	Unsure		
☐	☐	☐	1.	Patient received medically necessary care from a Resurrection Hospital. Check all hospitals where care was received: ☐ Resurrection Medical Center ☐ Saint Mary of Nazareth Hospital ☐ Holy Family Medical Center ☐ West Suburban Medical Center ☐ Our Lady of the Resurrection Medical Center ☐ St. Elizabeth Hospital ☐ Saint Francis Hospital ☐ Westlake Community Hospital ☐ St. Joseph Hospital
☐	☐	☐	2.	Patient received care between September 16, 2001 and September 19, 2008. Circle all years when care was received: 2001 2002 2003 2004 2005 2006 2007 2008
☐	☐	☐	3.	Patient **either** (a) has an outstanding bill for Resurrection hospital services **or** (b) had bills for Resurrection hospital services totaling more than $500 in a single year and paid some or all of the bills.
☐	☐	☐	4.	Patient **either** (a) lived in Cook County (or an adjacent county) **or** (b) received emergency care at a Resurrection Hospital.
☐	☐	☐	5.	Patient received medically-necessary hospital services.
☐	☐	☐	6.	Patient was not covered for hospital services at the time services were received by a healthcare savings account, a private insurance policy or health plan providing hospital benefits (including, but not limited to, any policies or plans sponsored or administered by employers, unions, mutual benefit associations, or workers' compensation; any ERISA plan; Medicare, Medicaid, SCHIP, or CHAMPUS; or other third-party coverage applicable to all or part of any hospital bill), or indemnity payor.

STEP 2: About the Patient

Last Name **First Name** **M. I.**

Address **Dept/Floor/Suite/Room**

City **State** **Zip Code** —

Social Security Number — — **Date of Birth** — —

Home Phone — — **Work Phone** — —

PLEASE CONTINUE ON REVERSE SIDE

STEP 3: About the Person Responsible for Paying the Bill

Last Name **First Name** **M. I.**

Address **Dept/Floor/Suite/Room**

City **State** **Zip Code**

Social Security Number **Relationship to Patient**

Home Phone **Work Phone**

Complete the following for the patient for each year care was received:

	2001	2002	2003	2004	2005	2006	2007	2008
Total Household Members:								
Yearly Household Income:								
Estimated Home Equity:								
Other Income (child support, interest payments, pension):								
Other Assets (savings, stocks, money market, CDs):								

YOU MUST RETURN THIS FORM WITH COPIES OF DOCUMENTS LISTED IN THE INSTRUCTIONS.

STEP 4: Authorize and Sign (Person Responsible for Paying the Bill)

☐ I authorize Resurrection Health Care to disclose my name and address, set forth above, to George S. Bellas, Esq. at Clifford Law Offices PC (Class Counsel) so that Class Counsel may assist me with my claim.

I hereby declare that the above information is true to the best of my knowledge and belief, and that I understand it is made for use as evidence in court and is subject to penalty for perjury. I further understand that any false information could result in my ineligibility for, or require me to repay, any voucher from Resurrection based on that information.

Responsible Person's Signature _____ Date: _____/_____/_____

Date: November _____, 2008

Dear Resurrection Hospital Patient:
You are receiving this letter because you may be eligible to participate in a class action settlement. The Court has preliminarily approved a class action settlement that may entitle you to a refund in the form of a voucher or a recalculation of an existing medical bill that you have received from Resurrection. Please read the following instructions carefully. Fill out the claim form on the reverse. The statements in Step 1 will allow you to determine if you are eligible to participate.

If you have questions, please call 877-498-8914 (toll free). Phone hours are 8:30 a.m. – 5:30 p.m. central time.

Thank you,
Resurrection Health Care

INSTRUCTIONS

Use this form to submit a Claim as allowed by the Class Action Lawsuit

Use one form for each person who received care. You may use the same form if the patient received care in different years.

Claim forms must be postmarked by February 16, 2009. If the form is not complete with required **Documentation** (defined below), Resurrection Health Care may not process your claim form. Submitted forms and tax records will not returned to you.

To Fill Out This Form:

Step 1: Put a "√" next to True, False, or Unsure for EVERY statement. Put a "√" next to all hospitals where you received care. Put a circle around all years where you received care.

Step 2: Fill out information about the patient.

Step 3: Fill out information about the person who was responsible for paying the medical bill at the time care was received. The person responsible for paying the bill may be the patient. You must submit copies of the following **Documentation** for the patient:

- Proof of identification (at least ONE of the following: driver's license; state ID; ID card; passport; green card; matricula consular)
- Proof of income (copies of Income and Property Tax Records for each year care was received; if you do not have Income or Property Tax Records, submit verification of your income for each year care was received. Examples: bank statement, account statements for stocks and money market funds)

Step 4: Put a "√" next to the box if you authorize Resurrection Health Care to disclose your name and address to George Bellas of Clifford Law Office (Class Counsel) in the case of Niewinski v. Resurrection Health Care Corp., No. 04 CH 15187, so that Class Counsel may assist you with your claim. By checking the box, you understand and agree:

A. I may revoke this authorization at any time by sending written notice of my revocation to Resurrection at the address set forth below; however, any such revocation will not apply to any information already disclosed pursuant to this authorization.
B. I understand that the information disclosed under this authorization may be redisclosed by the recipient to the extent allowed by law.
C. I may refuse to sign this authorization. My refusal will not adversely affect my ability to receive treatment, to enroll in a health plan, to be eligible for health care benefits, or to obtain payment for health care services.
D. If I am signing on behalf of the patient, I declare under penalty of perjury that I have authority to act on behalf of the patient.

The person responsible for paying the bill should sign the form. Return this form with COPIES of **Documentation** to:
RESURRECTION HEALTH CARE SETTLEMENT ADMINISTRATION
P.O. BOX 56798
JACKSONVILLE, FL 32241-6798