AETNA CLASS ACTION LIPEDEMA SURGERY CLAIM FORM

You are receiving this Claim Form because you are a Class Member in the class action entitled *Michala Kazda v. Aetna Life Insurance Company*, Case No. 3:19-cv-02512-WHO.

If Aetna denied your pre-authorization or post-service request for liposuction to treat your lipedema ("Lipedema Surgery") on the ground that Lipedema Surgery was "cosmetic," "investigational" or "experimental", and you proceeded to pay out-of-pocket for the surgery, and were not reimbursed by any other source (including, for example, other insurance or Medicare) for which you owe no reimbursement obligation, then you may use this Claim Form to request reimbursement as part of the Settlement of this class action.

You must submit a claim form by September 21, 2026, to Atticus Administration at the address set forth below. You must also include with your claim form:

(1) Documentation sufficient to show you had Lipedema Surgery (such as an operative report, other clinical records or sufficiently detailed payment records);

(2) Proof of payment (checks, wire transfer receipts, invoices reflecting actual payment, or other reasonable proof substantiating payment) showing net out-of-pocket payments to medical providers for the surgery, and;

The Settlement Administrator will make and communicate a decision about whether your claim will be reimbursed within 90 days of receiving the Claim Form.

If you have any questions about this form, or need an additional form, please contact the Settlement Administrator at 800-873-2890. Submitting this Claim Form does not guarantee that you will receive benefits.

Instructions:

Please read all of the instructions and complete the Claim Form as indicated below.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent reimbursement for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

When you have completed this Claim Form, please mail it—along with supporting documentation—directly to the TPA at the address listed below:

Kazda v. Aetna Life Insurance Company
c/o Atticus Administration
PO Box 64053
Saint Paul, MN 55164

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AETNA MEMBER (OR FORMER MEMBER) INFORMATION				
Member (or former member) Name Last	First			Middle
Home Address		Date of Birth (Mo / Day / Yr)		Primary Phone Number
City	State	Zip	Patient Sex	Is this a new address? YES ☐ NO ☐
Aetna Member ID No (for current members).				

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OTHER COVERAGE OR BENEFITS INFORMATION

OTHER INSURANCE

Have you received coverage or benefits from any other health plan or health insurance company for Lipedema Surgery?

YES ☐ NO ☐

If the answer is "Yes" to the above, what date did you receive coverage or benefits and what were the amounts of benefits received?

Date(s): Amount(s):

Name of other health plan or insurance company		Policy No. / Subscriber No.		
Health Plan or Insurance company address	City	State	Zip	
Name of policyholder		Social Security No.	Date of Birth	
Employer Name	Employer Address	City	State	Zip

MEDICARE

If you were enrolled in Medicare when you paid out-of-pocket for Lipedema Surgery, indicate the parts you were enrolled in at the time of coverage:

PART A ☐ PART B ☐

If you were enrolled in Medicare when you paid out-of-pocket for Lipedema Surgery what dates were you enrolled?

Effective Date:_____ End Date:_____

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medically-related facility to furnish to Aetna, its agents, designees, or representatives, any and all information pertaining to medical treatment for purposes of reviewing, investigating, or evaluating this claim. I also authorize Aetna, its agents, designees, or representatives to disclose to a hospital or health care service plan, insurer, or self-insurer any such medical information obtained if such disclosure is necessary to allow the processing of any claim.

This authorization becomes effective immediately and will remain in effect until September 21, 2027.

A photocopy or scan of this authorization will be considered as effective and valid as the original.

I certify that the above statements are correct.

AETNA MEMBER, FORMER MEMBER, OR PARENT OR LEGAL GUARDIAN'S SIGNATURE	PRINT NAME	DATE
_____	_____	_____

CONTINUED ON NEXT PAGE

INFORMATION RELATED TO YOUR LIPEDEMA SURGERY

(3) Instructions: Please complete this section to the best of your ability.

In addition, please enclose:

(i) Documentation sufficient to show you had Lipedema Surgery (such as an operative report, other clinical records or sufficiently detailed payment records); and

(ii) Proof of payment (checks, wire transfer receipts, invoices reflecting actual payment, or other reasonable proof substantiating payment) showing net out-of-pocket payments to medical providers for the surgery.

You can request a copy of your clinical records and bills from your provider if you have not kept a copy.

The Settlement Administrator cannot process your reimbursement without adequate proof of payment.

Dates Of Service	Place Of Service	Health Care Provider	Service Received	Total Charge	Amount You Paid For Service
Example June 17, 2019	Santa Rosa Medical Group	John Smith	liposuction	$45,000	$30,000
1.					
2.					
3.					
4.					

I AFFIRM THAT I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ON THIS CLAIM FORM AND ACCOMPANYING CLAIM FORM DOCUMENTATION PAGE(S) TO THE BEST OF MY ABILITY. I UNDERSTAND THIS CLAIM IS SUBJECT TO REVIEW AND VERIFICATION, AND THAT THE SETTLEMENT ADMINISTRATOR MAY REQUEST THAT I SUBMIT ADDITIONAL INFORMATION TO SUPPORT MY CLAIM FOR REIMBURSEMENT,

AENTA MEMBER, FORMER MEMBER, OR PARENT OR LEGAL GUARDIAN'S SIGNATURE	DATE
_____	_____