AETNA CLASS ACTION LUMBAR ARTIFICIAL DISC REPLACEMENT
FORMER AETNA MEMBER FUTURE SURGERY CLAIM FORM

You are receiving this Claim Form because records indicate you are a Class Member in a consolidated class action lawsuit *Brian Hendricks and Andrew Sagalongos v. Aetna Life Insurance Company*, Case No. 2:19-cv-6840-AB and *Andrew Howard v. Aetna Life Insurance Company*, Case No. 2:22-cv-01505-AB in the U.S. District Court for the Central District of California (the "*Hendricks-Howard* class action").

If you do not currently receive health coverage through Aetna, but Aetna denied in the past your precertification request for single-level lumbar artificial disc replacement (L-ADR) surgery on the ground that L-ADR was "investigational" or "experimental," and you have not had an L-ADR surgery, you may use this form to request relief under the *Hendricks-Howard* class action settlement for a future L-ADR.

If you have already had an L-ADR surgery, do not submit this form. To seek reimbursement under the Settlement for a past surgery—up to a maximum of $55,000—you may submit the Reimbursement Claim Form instead.

If you currently receive health coverage through Aetna: Do not submit this form. You have until December 28, 2026, to complete and submit a different form, the Future Surgery Claim Form, to Atticus Administration at the address below.

If you do not currently receive health coverage through Aetna: You have August 31, 2026, to submit this form to Atticus Administration at the address below. After you submit this form, you will receive a response indicating whether you are eligible for reimbursement for a future single-level L-ADR surgery. If you are eligible, you then have 180 days from eligibility notice mailing to submit the separate Future Surgery Claim Form to Atticus Administration at the address 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.

Instructions:

Please read and follow all the instructions in this Claim Form. If you have any questions about this form, or if you need an additional form, contact the Settlement Administrator at 1-800-243-4551. When you have completed this Claim Form, please mail it—along with supporting documentation—directly to the Settlement Administrator at the address listed below:

Hendricks and Howard v Aetna Life Insurance Co.
c/o Atticus Administration
PO Box 64053
Saint Paul, MN 55164
Email: LADRSurgerySettlement@atticusadmin.com

CLASS MEMBER INFORMATION				
Last Name	First Name			Middle Name
Home Address		Date of Birth (Mo / Day / Yr)		Primary Phone Number
City	State	Zip	Patient Sex	Is this a new address? YES ☐ NO ☐
Are you currently enrolled in health coverage through Aetna? YES ☐ NO ☐				
If you checked the "YES" box in the row above, complete the additional rows below in this table.				
Aetna member ID number:				
Is your current Aetna health coverage group health coverage? YES ☐ NO ☐ I DON'T KNOW ☐				
Aetna coverage group name or employer name (if applicable):				
Aetna coverage group number (if applicable):				

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CURRENT COVERAGE OR BENEFITS INFORMATION

Are you currently enrolled in Medicare? If so, indicate the parts of Medicare in which you are enrolled. If you are not enrolled in Medicare, leave this box blank.

PART A ☐ PART B ☐ PART C (also called a Medicare Advantage Plan) ☐

Do you currently have any health insurance? YES ☐ NO ☐
Do you currently have health insurance through your job? YES ☐ NO ☐
Do you currently have health insurance you purchased for yourself (an individual plan)? YES ☐ NO ☐

If you currently have health insurance other than Medicare, provide the following information:

Name of 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

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INFORMATION ABOUT YOUR ABILITY TO GET COVERAGE FOR AN L-ADR SURGERY
Does your health insurance plan cover L-ADR under any circumstances? Check the "YES" box if your health insurance provides any kind of coverage for L-ADR, even if you do not yourself qualify for coverage. Check the "YES" box if you do not know whether you would qualify for coverage. Check the "NO" box only if your current health insurance does not cover L-ADR for any covered person under any circumstances. YES ☐ NO ☐
Complete the rest of this table only if you checked "NO" in the box above.
Do you currently receive health insurance through your work (an employer plan)? YES ☐ NO ☐
Do you have any reasonable ability to enroll in individual health coverage (sometimes called an exchange plan or an individual plan) that covers L-ADR under any circumstances? Check the "YES" box if any individual plan available to you on your state marketplace covers L-ADR for any covered person under any circumstances. Check the "YES" box even if your state of residence does not have a state marketplace, if any plan available to you on the federal health insurance marketplace (healthcare.gov) covers L-ADR for any covered person under any circumstances. YES ☐ NO ☐

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MEMBER CERTIFICATION	
I CERTIFY UNDER PENALTY OF PERJURY THAT I HAVE PROVIDED TRUE AND ACCURATE INFORMATION ON THIS CLAIM FORM TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT 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 RELIEF UNDER THE SETTLEMENT.	
SIGNATURE OF AETNA MEMBER OR FORMER MEMBER (or signature of parent or legal guardian if Member is under 18 years old): _____	DATE

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