



Class Member ID: 3088700000000

**MUST BE  
POSTMARKED  
NO LATER THAN  
MARCH 31, 2017**

**PROOF OF CLAIM FORM**

**RE: *Giercyk v. HealthExtras, LLC  
et al., 2:13-cv-6272-FSH-MAH***

For Office Use Only

**I WISH TO RECEIVE A SHARE OF THE SETTLEMENT.  
IMPORTANT: THIS CLAIM FORM MUST BE POSTMARKED ON OR BEFORE  
MARCH 31, 2017 AND MAILED TO THE FOLLOWING ADDRESS:**

HealthExtras Settlement Administrator  
Heffler Claims Group  
P.O. Box 60167  
Philadelphia, PA 19102

**Name:** \_\_\_\_\_  
*First Name* *M.I.* *Last Name*

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**State:** \_\_\_\_ **Zip Code:** \_\_\_\_\_ - \_\_\_\_\_

**Phone Number:** ( \_\_\_\_\_ ) - \_\_\_\_\_ - \_\_\_\_\_

**E-mail 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:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

