CLAIM REGISTRATION FORM / "QUICK PAY" ELECTION FORM

Claim Registration Form / "Quick Pay" Election Form Deadline (the "Registration Form Deadline"): March 4, 2025

Please provide the following information to the Notice and Claims Administrators by completing this Claim Registration Form (the "Registration Form") and emailing it to info@acutecarehospitalsettlement.com prior to completing the Claim Form. Capitalized terms not otherwise defined shall have the meanings ascribed to them in the Acute Care Hospital Class Action Settlement Agreements[1] (the "Settlement Agreements") in *San Miguel Hospital Corp., d/b/a Alta Vista Regional Hospital v. Johnson & Johnson, et al.*, Case No. 1:23-cv-00903-KWR-JFR (D.N.M.), available on the settlement website at www.acutecarehospitalsettlement.com. Each entity making a Claim ("Claimant") must submit a separate Registration Form.

To be eligible to make a Claim, the Claimant must fall within one or more of the following categories:

(1) Claimant is an Acute Care Hospital in the United States that treated patients diagnosed with opioid use disorder and/or other opioid-related conditions from January 1, 2009, through October 30, 2024, and is not owned or operated by a federal, state, county, parish, city, or other municipal government. To be considered an Acute Care Hospital under the Settlement Agreements, Claimant must (a) provide medical care and other related services for surgery, acute medical conditions or injuries for a period of treatment time that is, on average, less than 25 days; and (b) either (i) appear as either active or inactive in the American Hospital Directory® as a "short term acute care" hospital or a "critical access" hospital or (ii) have an emergency department that is subject to the Emergency Medical Treatment and Labor Act ("EMTALA");

(2) Claimant is listed on Exhibit A to the Acute Care Hospital Class Action Settlement Agreement for which it is submitting a Claim; and/or

(3) Claimant is one of the Plaintiffs in the Other Actions listed on Exhibit B to the Acute Care Hospital Class Action Settlement Agreement for which it is submitting a Claim.

Exhibits A and B to each Settlement Agreement are non-exhaustive lists and do not purport to identify all members of the Settlement Class for that particular Settlement.[2] A Class Member may be eligible to make a Claim for one or more Settlements.

A Claimant is ineligible for recovery under a particular Settlement Agreement if any of its Released Claims were released in any other settlement with the Settling Defendant(s) that are party

[1] "Acute Care Hospital Class Action Settlement Agreements" refers collectively to the Distributor Class Action Settlement Agreement with Acute Care Hospitals dated September 26, 2024, the Janssen Class Action Settlement Agreement with Acute Care Hospitals dated September 27, 2024, the Teva Defendants Class Action Settlement Agreement with Acute Care Hospitals dated September 30, 2024, and the Allergan Defendants Class Action Settlement Agreement with Acute Care Hospitals dated October 1, 2024 available at www.acutecarehospitalsettlement.com.

[2] Inclusion of an entity on Exhibit A and/or as a Plaintiff in the Other Actions listed on Exhibit B to a particular Settlement does not determine whether that entity is eligible for any other Settlement.

to that Settlement Agreement.[3] A Claimant may be ineligible for recovery under one or more Settlement Agreement(s), but still be eligible for recovery under other Settlement Agreements if it meets the eligibility criteria for those other Settlement Agreements.

A Claimant that submits a Registration Form or Claim Form may be contacted by representatives of Class Counsel or by the Notice and Claims Administrators for additional information regarding the Class Member's claims.

The Claim Deadline is 5:00 p.m. Central Standard Time **March 4, 2025**. **HOWEVER, in advance of this Claim Deadline you must first submit this Registration Form by the Registration Form Deadline on March 4, 2025 to allow sufficient time for submission of all other required documents and information required to process your Claim.** Your Claim will be rejected and you will be precluded from receiving an Allocated Amount by the Acute Care Hospital Class Action Settlement Agreements if this Registration Form is not received by the Registration Form Deadline. Do not send your Registration Form and Claim Form to the Court or to anyone other than the Notice and Claims Administrators.

A person who files a fraudulent claim on behalf of a Class Member may, at a minimum, be fined up to $500,000.00, imprisoned for up to five years, or both, in accordance with 18 U.S.C. §§ 152, 157.

[3] Exclusion of a Claimant from one Settlement Agreement on this basis does not necessarily prevent a Claimant from being eligible for the other Settlement Agreements identified in Footnote 1.

A. Claimant Information

Please provide the information in Section A for the Claimant:

1. Name of Acute Care Hospital:			
2. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
3. Ownership (Check the one that applies):	Current Owner ☐	Former Owner ☐	
4. Name of Operating Entity:			
5. Federal Employer Identification Number of Operating Entity:	_____-_____		

B. Contact Information

Please provide the information in Section B where notices should be sent:

<table>
<tr><td>1. Contact Name:</td><td colspan="3"></td></tr>
<tr><td>2. Contact Title:</td><td colspan="3"></td></tr>
<tr><td rowspan="3">3. Address:</td><td colspan="3">Street Address Line 1</td></tr>
<tr><td colspan="3">Street Address Line 2</td></tr>
<tr><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td>4. Phone:</td><td colspan="3">( ) -</td></tr>
<tr><td>5. Email:</td><td colspan="3"></td></tr>
<tr><td colspan="4">By filling out this Registration Form, you are deemed to consent to receipt of this notice by email.</td></tr>
</table>

For promptness and accuracy, we prefer to contact you by email and will do so if possible. Accordingly, please provide your email address. If necessary, we may also contact you by phone or by U.S. mail.

C. Attorney Information

1. Is your Acute Care Hospital submitting this Registration Form with the assistance of an attorney?

Yes ☐

No ☐

If yes, please provide your attorney's name, phone number, mailing address, and email:

1. Attorney Contact Name:			
2. Law Firm Name:			
3. Address:	Street Address Line 1		
	Street Address Line 2		
	City	State	Zip
4. Phone:	( ) -		
5. Email:			
6. Federal Employer Identification Number of Law Firm: _____-_____			
By filling out this Registration Form, you are deemed to consent to receipt of this notice by email.			

2. Do you want any potential payment mailed to your attorney?

Yes ☐

No ☐

D. Naloxone Kit Program Registration

Under the Teva Defendants Class Action Settlement Agreement ("Teva Settlement"), Class Members are eligible to receive, free of charge, Naloxone Hydrochloride Nasal Spray kits (4 mg strength) as listed in Teva's generics catalog, which can be viewed at www.tevagenerics.com through 2030 (the "Naloxone Kit Program"). Participation in the Naloxone Kit Program is voluntary, does not impact your ability to receive any other benefit, and is subject to the terms and conditions in the Teva Settlement and the Product Allocation Plan.

1. Do you want to register for the Naloxone Kit Program?

Yes ☐

No ☐

E. Calculation of Allocated Amount and Quick Pay Election

The Acute Care Hospital Class Action Settlement Agreements provide benefits to certain Claimants who can establish "Eligible Damages," and allocates available settlement funds to Qualifying Class Members ("Allocated Amount"). Copies of the Settlement Agreements and Plan of Allocation may be found at www.acutecarehospitalsettlement.com. To determine your Allocated Amount under these Settlement Agreements, you must submit claims data. For purposes of the Settlements, you, as a Class Member, are eligible for an Allocated Amount if you are a Qualified Class Member that treated patients with opioid use disorder and/or other opioid-related conditions and, as a result of that care, you suffered identifiable operational losses reflected in your claims data, including losses reflected in the charges to payments ratio for various treatment codes.

If you do not wish to complete a Claim Form and submit the data necessary to calculate an Allocated Amount, you may elect to receive your "Quick Pay Amount" instead. Subject to the Plan of Allocation, the Quick Pay Amount is $5,000 and will be disbursed within 45 days of the Effective Date of the Settlement Agreements. Any eligible Class Member may elect to receive their Quick Pay Amount by answering the questions below:

1. **Do you agree to be bound by the terms of each of the four Acute Care Hospital Class Action Settlement Agreements and to participate in the Quick Pay option?**

   Yes ☐ No ☐

If yes, please sign and verify below:

I, _____, am authorized on behalf of _____, ("Participant") to elect to participate in the "Quick Pay" option under the Plan of Allocation. By completing this "Quick Pay" box and signing my name, I understand that the Participant waives any objection to the Acute Care Hospital Class Action Settlement Agreements, requests payment of the Quick Pay Amount of $5,000, and that the Participant will be ineligible for any further Allocated Amount under those Settlement Agreements.

I understand this Quick Pay Amount will be reduced under the Plan of Allocation if one or more Settlements is not approved or if the Participant is ineligible to receive funds from one or more Settlements.

☐ I direct and authorize the Notice and Claims Administrators to process the Participant's Claim as a "Quick Pay" for the Participant to receive its Quick Pay Amount under the Plan of Allocation. Payment checks will be mailed to the law firm identified in Section C of this Claim Form if Yes was selected in Section C.2. If not working with an attorney or if No was selected in Section C.2, the check will be mailed to the contact person identified in Section B.1.

Signed: _____

Printed Name: _____

Printed Title: _____

F. Supporting Documentation

Important notices regarding submission to the jurisdiction of the Court in New Mexico

By the filing of this Registration Form, you hereby submit to the jurisdiction of the United States District Court, District of New Mexico for the purposes of this Claim.

Verification of Properly Submitted Claim

The benefits provided by the Acute Care Hospital Class Action Settlement Agreements are for the operational losses to Class Members resulting from providing treatment to individuals with substance use disorder, opioid use disorder, or other opioid-related conditions. By submitting this Registration Form, you verify that other than what you disclosed in this Registration Form, you have not otherwise been reimbursed or compensated for the costs and expenses you are seeking.

By submitting this Registration Form, you verify, under oath and penalty of perjury, that, to the best of your knowledge, all the damages for which you seek benefits in this Registration Form relate to your provision of medical treatment in an emergency department, inpatient, or outpatient setting at an Acute Care Hospital.

G. Certification

I certify that I am authorized to sign this Registration Form, and I understand that an authorized signature on this Registration Form serves as an acknowledgement that I have a reasonable belief that the information is true and correct.

I certify that the Settlement Class Member has authority to release all Released Claims as identified in the following Settlement Agreements on behalf of itself and all other entities who are Releasors by virtue of their relationship or association with it.

I certify that the Settlement Class Member I am submitting this Registration Form on behalf of is eligible to receive funds under the following Settlement Agreements:

1. **Distributor Class Action Settlement Agreement with Acute Care Hospitals**
   ☐ YES ☐ NO
2. **Janssen Class Action Settlement Agreement with Acute Care Hospitals**
   ☐ YES ☐ NO
3. **Teva Defendants Class Action Settlement Agreement with Acute Care Hospitals**
   ☐ YES ☐ NO
4. **Allergan Defendants Class Action Settlement Agreement with Acute Care Hospitals**
   ☐ YES ☐ NO

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Your typed signature and submission of this Registration Form will have the same force and effect as if you signed the Registration Form on paper, which you may do alternatively.

Signature: _____

Executed on date (MM/DD/YYYY): _____

Print the name of the person who is completing and signing this claim.

Name (First Middle Last): _____

Title: _____

Acute Care Hospital: _____

Address: _____

_____

_____

Contact Phone: _____

Email: _____