Mail to:
*Adlouni v. Regents of University of California*
UCLA Health System Claims Administrator
P.O. Box 3058
Portland, OR 97208-3058

**Must Be Postmarked Or Submitted Online No Later Than June 18, 2019**

# Preventive Measures Claim Form

Use this Claim Form if, after learning of the cyberattack on UCLA Health Network, you incurred costs to prevent identity theft. You may be entitled to receive up to $5,000 for reimbursable costs. Examples of reimbursable costs include costs incurred for credit monitoring or reporting, the purchase of identity theft protection, card cancellation or replacement, freezes or alerts on credit reports, and costs to replace driver's license, ID card or Social Security number.

The preventive measures must have been taken between **July 17, 2015,** and **March 20, 2019**.

**FIRST NAME** **M.I.** **LAST NAME**

**PRIMARY ADDRESS**

**MORE SPACE FOR PRIMARY ADDRESS**

**CITY** **STATE** **ZIP CODE**

**EMAIL ADDRESS FOR ADMINISTRATOR TO CONTACT YOU REGARDING YOUR CLAIM**

**DAYTIME TELEPHONE NUMBER** – – **EVENING TELEPHONE NUMBER** – –

**CLAIM/UNIQUE ID (LOCATED ON YOUR NOTICE)**

Describe below the preventive measures you took and the costs you incurred for each preventive measure.

If you have any documents supporting the costs you incurred, submit them with this Claim Form. Documents supporting your claim must be provided if the documents are reasonably available to you. Documents supporting your claim could include credit card statements, bank statements, invoices or receipts, telephone records, or any other writing that supports your claim.

☐ Check here if you are submitting documents.

I affirm under penalty of perjury that I incurred the costs listed above at date(s) between **July 17, 2015,** and **March 20, 2019**, and I have not otherwise been reimbursed for these costs. If I am reimbursed in the future, I will inform the Claims Administrator. I understand my claim may be audited and if so, I will provide information as requested and available, which may be required to process the claim.

SIGNATURE

DATED MM – DD – YY

Please submit your claim either online at www.UCLAHealthCyberSettlement.com or mail this completed Claim Form, postmarked by **June 18, 2019**:

UCLA Health System Claims Administrator
P.O. Box 3058
Portland, OR 97208-3058