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, 2021

Unreimbursed Losses Claim Form

Use this Claim Form if you incurred any losses that resulted from identity theft or the unauthorized use of your personally identifiable information including your health information. You may be entitled to receive up to $20,000 for unreimbursed losses. Examples of reimbursable losses include charges, late fees, declined payment fees, overdraft fees, returned check fees, and any other losses that could have resulted from the cyberattack on the UCLA Health Network. You can be reimbursed for the time you spent addressing these issues up to six hours at $15 per hour.

Your losses must have been incurred between **September 1, 2014**, and a date to be determined, which will be no sooner than **June 18, 2021**.

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)

Part A. Describe below the losses to you resulting from identity theft or unauthorized use of your personally identifiable information and/or your personal health information. Include the amount of your losses.

If you have any documents supporting the losses you incurred, please submit them with this Claim Form. Documents supporting your claimed losses must be provided if the documents are reasonably available to you.

☐ Check here if you are submitting documents.

Part B. For each loss described above, if you wish to receive a reimbursement for the time you spent addressing them, describe and state the amount of time you spent dealing with the situation.

Total number of hours claimed: ☐

I affirm under penalty of perjury that the losses listed with this Claim Form occurred on or after **September 1, 2014**, and I have not otherwise been reimbursed for these losses. 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 to me, 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, 2021**:

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