MUST BE RECEIVED ON OR BEFORE March 7, 2016 Lasseter v. Rite-Aid Corporation c/o GCG P.O. Box 10204 Dublin, OH 43017-3904 Toll-Free: 1 (888) 985-9384



# Rite Aid Nationwide Class Settlement Pharmacy Prescription Records

## **Claim Form**

#### How to Apply for a Payment from the Proposed Settlement

If you would like to submit a claim in the Rite Aid Nationwide Class Settlement, complete this form and mail it to the address below.

### YOUR CLAIM MUST BE RECEIVED ON OR BEFORE MARCH 7, 2016

#### MAIL YOUR CLAIM TO:

Lasseter v. Rite-Aid Corporation c/o GCG P.O. Box 10204 Dublin, OH 43017-3904

Attn: Rite Aid Nationwide Class Settlement

SECTION A: CLAIMANT INFORMATION	
Full Name (if you are a law firm or a business entity, state firm name or entity name):	
If you are a law firm or business entity submitting this Claim Form, please state the name of the Rite Aid custome whose behalf you requested Pharmacy Prescription Records:	r on
Street Address:	
City/Town: State: ZIP:	
Phone:	
Email:	



SECTION B: PERSONAL REPRESENTATIVE OR GUARDIAN OF CLAIMANT
Are you an executor, administrator, or otherwise have authority to act on behalf of a deceased Rite Aid customer or his/her estate?  Yes  No
If you checked "Yes" to the question above, you must attach documents establishing your authority to act and receive assets as the Personal Representative.
Are you a legal guardian or a conservator of the Claimant identified in Section A?  Yes  No
If you checked "Yes" to the question above, you must attach documents establishing your authority to act and receive assets for the Claimant.
SECTION C: VERIFICATION OF PAYMENT
In submitting this Claim Form, you are verifying that the following statements are true and correct:
<ol> <li>That you are a person or entity who paid Rite Aid Hdqtrs. Corp. or Rite Aid Corporation a Fixed Records Charge of either \$50 or \$85 for the production of customer pharmacy records.</li> </ol>
<ol><li>You have not received reimbursement from any person or entity for the cost of that charge by any client, principal or third party.</li></ol>
SECTION D: SETTLEMENT ADMINISTRATOR HAS SOLE AUTHORITY TO ACCEPT OR REJECT YOUR CLAIM
Garden City Group, LLC, who is serving as the Settlement Administrator, will decide whether to approve or reject your claim based on the information provided in this Claim Form and based upon other proof requested by the Settlement Administrator (in its discretion). As a result, it is important that you complete this Claim Form in its entirety and, if requested, that you provide the proof and other documentation sought by the Settlement Administrator. If your claim is rejected, you will be notified by the Settlement Administrator and be provided fourteen (14) days to correct any deficiency. You may also appeal the denial of your Claim Form to the Court overseeing the Settlement.
If your claim is accepted, the Settlement Administrator will send you at a later date the settlement relief to which you are entitled under the settlement's terms. Please be patient.
Under penalty of perjury, I certify that all of the information provided on this Claim Form is true, correct and complete.
Signature:
Print Name:
Date: