

**Your claim must
be submitted
online or
postmarked by:
March 16, 2026**

CLAIM FORM

Katherine Layman v. Legacy Health
Circuit Court of Multnomah County
Case No. 25CV40104

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GENERAL INSTRUCTIONS

You are a Settlement Class Member if you are a patient of Legacy Health residing in the United States (1) who was invited to and did register for a Legacy Health patient portal account from February 18, 2019, through December 31, 2020 (“Category 1”), and (2) do not fall within Category 1, but otherwise logged into Legacy Health’s Patient Portal from January 1, 2021, through February 9, 2024. You may submit a Claim for a settlement benefit, outlined below.

Please refer to the long form Notice posted on the Settlement Website www.PixelLegacyHealthSettlement.com, for more information on submitting a Claim Form and if you are part of the Settlement Class.

To receive a settlement benefit from this settlement, you must submit the Claim Form by March 16, 2026.

This Claim Form may also be mailed to the address below. Please type or legibly print all requested information, in blue or black ink. Mail your completed Claim Form, including any supporting documentation, by U.S. mail to:

Layman v. Legacy Health
P.O. Box 25226
Santa Ana, CA 92799

Settlement Class Members under the Settlement Agreement will be eligible to receive any of the following benefits:

- ❖ **Cash Payment:** Each Settlement Class Member may submit a Claim for a cash payment of **\$15**;
- ❖ **Medical Shield Complete:** All Settlement Class Members will be entitled to automatically receive a code and link for redeeming **one (1) year of Medical Shield Complete** product, free of charge and without the need to submit any Claim, which product includes the following features: One Bureau of Credit Monitoring, Health Insurance Plan ID Monitoring, Medicare Beneficiary Identifier ID Monitoring, Medical Record Number Monitoring, Dark Web Monitoring, Health Savings Account Monitoring, National Provider Identifier Monitoring, \$1,000,000 Identity Theft Insurance, High-Risk Transaction Monitoring, Security Freeze Assistance, and Victim Assistance.

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I. SETTLEMENT CLASS MEMBER NAME AND CONTACT INFORMATION

Provide your name and contact information below. You must notify the Settlement Administrator if your contact information changes after you submit this Claim Form.

First Name

Last Name

Street Address

City

State

Zip Code

Email Address

II. PROOF OF SETTLEMENT CLASS MEMBERSHIP

- Check this box to certify you are a patient of Legacy Health residing in the United States (1) who was invited to and did register for a Legacy Health patient portal account from February 18, 2019, through December 31, 2020 (“Category 1”), and (2) do not fall within Category 1, but otherwise logged into Legacy Health’s Patient Portal from January 1, 2021, through February 9, 2024.

Enter the Unique ID Number provided on your Email Notice:

Unique ID: _____

III. CASH PAYMENT

Each Settlement Class Member may submit a Claim for a cash payment of \$15.

- Yes, I choose a cash payment of \$15.

IV. MEDICAL SHIELD COMPLETE

All Settlement Class Members were sent a code and link for redeeming one (1) year of Medical Shield Complete product, free of charge and without the need to submit any Claim, which product includes the following features: One Bureau of Credit Monitoring, Health Insurance Plan ID Monitoring, Medicare Beneficiary Identifier ID

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Monitoring, Medical Record Number Monitoring, Dark Web Monitoring, Health Savings Account Monitoring, National Provider Identifier Monitoring, \$1,000,000 Identity Theft Insurance, High-Risk Transaction Monitoring, Security Freeze Assistance, and Victim Assistance.

The code and link for your Medical Shield Complete was previously sent to you as part of the email Notice of this Settlement. If you have misplaced your Notice containing the code and link, please contact the Settlement Administrator at (833) 647-9039.

You may also select the cash payment benefit above.

V. PAYMENT

Please select one of the following payment options if you are seeking a payment under Section III.

PayPal - Enter your PayPal email address: _____

Venmo - Enter the mobile number associated with your Venmo account: ____ - ____ - ____

Zelle - Enter the mobile number or email address associated with your Zelle account:

Mobile Number: ____ - ____ - ____ or Email Address: _____

Physical Check - Payment will be mailed to the address provided in Section I above.

VI. ATTESTATION & SIGNATURE

I swear and affirm under the law of my state that the information I have supplied in this Claim Form is true and correct to the best of my recollection, and that this form was executed on the date set forth below.

Signature

Date

Print Name