

**PROOF OF CLAIM FORM FOR THE HEALTH NET SETTLEMENT FUND AND  
ELECTION OF CONTRIBUTION TO CHARITABLE FOUNDATION**

DEADLINE FOR SUBMISSION: Postmarked by SEPTEMBER 21, 2005.

If you would like for the portion of the settlement fund that you are entitled to receive to be donated to a charitable foundation that is dedicated to promoting high quality healthcare, you may do so by selecting from one of the 20 charitable foundations listed below. All settlement funds that are not paid to members of the Class, or to a designated foundation, will be donated to Physicians' Foundation for Health Systems Innovations.

If you do not submit this form to the Settlement Administrator prior to SEPTEMBER 21, 2005, you will forfeit your right to participate in the settlement fund.

By submitting a Proof of Claim Form, you are agreeing to be subject to the jurisdiction of the United States District Court for the Southern District of Florida for any proceedings relating to that Proof of Claim. Capitalized terms used in this Proof of Claim Form that are not otherwise defined herein have the meaning assigned to them in the Settlement Agreement.

Mail your completed Proof of Claim Form, with any required documentation, to the Settlement Administrator at the following address:

Health Net Physician Settlement Administrator  
PO Box 1018  
Minneapolis, MN 55440-1018  
1-866-254-8048

**LIST OF CHARITABLE FOUNDATIONS**

**National Foundations**

1. Physicians' Foundation for Health Systems
2. Physicians' Foundation for Health Systems Innovations

**State Foundations**

3. Arlington County Medical Society Foundation
4. John P. Bowler, M.D., Memorial Library (New Hampshire Medical Society)
5. California Medical Association Foundation
6. CSMS Physicians' Health and Education Fund (Connecticut State Medical Society)
7. El Paso County Medical Society Foundation
8. Florida Medical Foundation (Florida Medical Association)
9. The Institute of Medicine and Public Health of New Jersey, Inc. (Medical Society of New Jersey)
10. Louisiana State Medical Society Educational and Research Foundation
11. Medical Association of Georgia Institute for Excellence in Medicine, Inc.
12. Medical, Educational and Scientific Foundation of New York, Inc. (Medical Society of the State of New York)
13. Medical Society of Northern Virginia Foundation
14. Nebraska Medical Foundation (Nebraska Medical Association)
15. North Carolina Medical Society Foundation, Inc.
16. South Carolina Medical Association Foundation
17. Tennessee Medical Foundation (Tennessee Medical Association)
18. Texas Medical Association Special Funds Foundation
19. Vermont Medical Society Education and Research Foundation, Inc.
20. Washington State Medical Education and Research Foundation (Washington State Medical Society)

**SECTION I**

**IF YOU ARE A MEMBER OF THE CLASS WHO HAS RETIRED FROM THE PRACTICE OF MEDICINE SUBSEQUENT TO AUGUST 4, 1990 OR ARE THE LEGAL HEIR OR REPRESENTATIVE OF A DECEASED CLASS MEMBER, PLEASE COMPLETE THIS PORTION OF THE FORM.**

I certify that I have reviewed the enclosed notice of proposed settlement and that I am either a member of the class (as described in such notice of proposed settlement) who has retired from the practice of medicine subsequent to August 4, 1990 or that I am the legal heir or representative of a deceased member of the class. *If you are the legal heir or representative of a deceased member of the class, you must attach documentation to confirm your status.*

- By checking this box, I am directing the Settlement Administrator to pay to me my pro rata portion of the settlement fund that has been reserved for retired and deceased physicians.
- By checking this box, I am directing the Settlement Administrator to donate my pro rata portion of the settlement fund to the following charitable foundation, which I have selected from the list on Page 1 of the Claim Form (select only one).

Name of Foundation: \_\_\_\_\_

**Please continue to Section III to complete this Claim Form.**

**SECTION II**

**IF YOU ARE A MEMBER OF THE CLASS AND AN ACTIVELY-PRACTICING PHYSICIAN, PLEASE COMPLETE THIS PORTION OF THE FORM.**

Members of the Class (as described in the enclosed notice of proposed settlement) who are active physicians are entitled to receive a pro rata amount of the portion of the settlement fund that is not reserved for retired or deceased physicians. Your settlement payment will be based upon the amount of payments received by you from Health Net in payment for services during the three year period from 2002 to 2004 (or for any consecutive three-year period from January 1, 1996 through December 31, 2004 if you elect to submit payment records).

Active physicians that received no payments from Health Net, or payments from Health Net of less than \$5,000, during the three year period from 2002 to 2004 will receive a settlement payment that is equal to the "base amount" of the settlement fund that is being paid to active physicians in the settlement.

Active physicians that received payments from Health Net of \$5,000 or more, and less than \$50,000, during the three year period from 2002 to 2004 will receive a settlement payment that is equal to five times the "base amount."

Active physicians that received payments from Health Net of \$50,000 or more during the three year period from 2002 to 2004 will receive a settlement payment that is equal to ten times the "base amount."

To simplify the process of obtaining payment from Health Net, members of the class (as described in the enclosed notice of proposed settlement) who are actively-practicing physicians may sign this claim form and submit it to the Settlement Administrator prior to SEPTEMBER 21, 2005 without any additional documentation, in which event the amount of the settlement fund which each such active physician is entitled to receive shall be determined based upon the active physician's certification as to the amount of Health Net payments received from 2002 to 2004 and, at the Settlement Administrator's discretion, on Health Net's books and records for the three year period from 2002 to 2004. Alternatively, active physicians may elect to submit to the Settlement Administrator proof of their payments from Health Net, in the form of 1099 forms or other forms of proof, to show the amounts of payments received from Health Net during any consecutive three-year period from January 1, 1996 through December 31, 2004 to justify the amount due to such active physician from the settlement fund. Active physicians that have been paid through Physician Organizations or Physician Groups (including without limitation Delegated Entities) may submit to the Settlement Administrator proof of the amounts received during any consecutive three-year period from January 1, 1996 through December 31, 2004 for providing services to members of plans offered or administered by Health Net.

Physician Groups and Physician Organizations may submit proofs of claim on behalf of physicians employed by or otherwise working with them without the necessity of individual signatures from the individual physician, if authorized to do so by such physicians.

Any questions about this procedure or proof that will be accepted should be addressed to the Settlement Administrator at:

Health Net Physician Settlement Administrator  
PO Box 1018  
Minneapolis, MN 55440-1018  
1-866-254-8048

I certify that I have reviewed the enclosed notice of proposed settlement and that I am a member of the Class (as described in the enclosed notice of proposed settlement) and am an actively-practicing physician.

For purposes of determining which box to check below, "Health Net" means any of the present or former affiliates of Health Net, Inc. that provided coverage to health benefit plan members. Please refer to the Health Net affiliated companies listed in the enclosed notice of proposed settlement. In determining your gross receipts, you should include amounts paid by Health Net directly or by intermediaries for providing covered services to Health Net members. For example, you may have provided services to Health Net members through an intermediary that contracted with Health Net to provide the services, for example, an IPA, medical group, organized delivery system, physician hospital organization, etc. In determining your gross receipts for providing covered services to Health Net members, you should also include amounts you received from such intermediaries for treating Health Net members.

**Check ONLY ONE of the following FOUR boxes:**

- By checking this box, I certify that my gross receipts for providing covered services to Health Net members during the three calendar year period of 2002, 2003 and 2004 were **less than \$5,000**.
- By checking this box, I certify that my gross receipts for providing covered services to Health Net members during the three calendar year period of 2002, 2003 and 2004 were **at least \$5,000 but less than \$50,000**.
- By checking this box, I certify that my gross receipts for providing covered services to Health Net members during the three calendar year period of 2002, 2003 and 2004 were **\$50,000 or greater**.
- By checking this box, I certify that my gross receipts for providing covered services to Health Net members during another consecutive three year period since January 1, 1996, were in the amount shown below and are supported by the enclosed documents evidencing such receipts. **Please fill in all three lines below and attach your proof of receipts.**

3-Year Period: \_\_\_\_\_

Check one box to indicate your range of receipts for this 3-year period for providing covered services to Health Net members:

Under \$5,000       \$5,000–50,000       Over \$50,000

Description of Proof Attached: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**All actively practicing physicians should also check one of the following two boxes:**

- By checking this box, I am directing the Settlement Administrator to pay to me my pro rata portion of the settlement fund that has been reserved for active physicians.
- By checking this box, I am directing the Settlement Administrator to donate my pro rata portion of the settlement fund to the following charitable foundation, which I have selected from the list on Page 1 of the Claim Form (select only one).

Name of Foundation: \_\_\_\_\_

**Please continue to Section III to complete this Claim Form.**

