UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

MDL NO.: 1334

IN RE: MANAGED CARE LITIGATION

THIS DOCUMENT RELATES ONLY TO
PROVIDER TRACK CASES

CIGNA HEALTHCARE PHYSICIAN SETTLEMENT

PROOF OF CLAIM FORM
FOR CATEGORY A SETTLEMENT FUND CLAIM
AND
ELECTION OF CONTRIBUTION TO FOUNDATION

Deadline for Submission: Postmarked By [_____] [180 days after commencement of the Claims Period]

EXHIBIT 10

THE CATEGORY A SETTLEMENT FUND

The Payment: CIGNA HealthCare has established the Category A Settlement Fund in the amount of Thirty Million Dollars ($30,000,000) as one part of the consideration provided to Class Members under the CIGNA Settlement. Each Class Member has the option of electing to receive a share of the Category A Settlement Fund by submitting this Proof of Claim Form. **If you elect to receive payment from the Category A Settlement Fund, you are not eligible to submit claims for Category One Compensation, Category Two Compensation or Medical Necessity Denial Compensation.**

The Formula: After the deadline for submission of Category A Settlement Fund Proofs of Claim, the Settlement Administrator will determine the total number of Class Members filing Valid Proofs of Claim. The Settlement Administrator will also determine the total number of Valid Proofs of Claim filed: 1) by or on behalf of retired and deceased Physicians and 2) by Physicians in active practice. The total number of valid claim submissions by or on behalf of retired and deceased Physicians will be doubled to reflect the fact that each such claimant will receive twice the share of the Category A Settlement Fund as will Physicians in active practice. Retired and deceased Physicians will receive this doubled amount because they will not receive the benefit of the prospective consideration provided by CIGNA Health Care under the terms of the Settlement. The Settlement Administrator will add the total number of Physicians in active practice submitting Valid Proofs of Claim to the doubled number of retired and deceased Physician submitting such claims. That total will be divided into Thirty Million Dollars ($30,000,000). The result is the base amount to be distributed to each Class Member submitting a Valid Category A Settlement Fund Proof of Claim, with twice the base amount to be distributed to an account of each retired or deceased Physician.

Election of Payment: If you decide to submit a claim for payment from the Category A Settlement Fund, you may elect:

1) to receive your share of the Fund; or

2) to direct that your share be contributed on your behalf to the Foundation described below or to a foundation established by any Signatory Medical Society on your behalf.

THE FOUNDATION

As part of the Settlement Consideration, CIGNA HealthCare has established a non-profit charitable Foundation that will be dedicated to promoting high quality health care and shall give particular emphasis to initiatives that assist Physicians to improve/enhance the quality of care received by patients and to enhance the delivery of care to the disadvantaged members of the public.

CIGNA HealthCare has made a contribution of Fifteen Million Dollars ($15,000,000) in initial funding of the Foundation. Additional amounts may be contributed to the Foundation from the Category A Settlement Fund and the Claim Distribution Fund established by CIGNA HealthCare, pursuant to the terms of the Settlement Agreement.

Each Class Member who chooses to file a Proof of Claim for payment from the Category A Settlement Fund has the option to elect that his, her or its share of the Category A Settlement Fund be contributed to the Foundation or to a foundation established by any Signatory Medical Society on his, her or its behalf.

- *Payment from the Category A Settlement Fund is available to all Class Members, including (1) Physicians in active practice, (2) retired Physicians who were in practice on or after August 4, 1990 and (3) the heirs or legal representatives of deceased Physicians who were in practice on or after August 4, 1990.*

- *This Proof of Claim Form should be used by all Class Members who wish to submit a claim for payment from the Category A Settlement Fund.*

- *This Proof of Claim Form should also be used by Class Members who submit a claim for payment from the Category A Settlement Fund and elect to contribute their share of the Category A Settlement Fund to the Foundation or to a foundation established by any Signatory Medical Society on their behalf.*

- *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.*

- ***PLEASE NOTE:** If you submit a Category A Settlement Fund Proof of Claim Form, you are not eligible for Category One Compensation, Category Two Compensation or Medical Necessity Denial Compensation.*

- *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.*

COMPLETE ALL SECTIONS AND SIGN THE CERTIFICATION.

SECTION I: PHYSICIAN INFORMATION

Name of Physician: _____

Name of Physician Group, Physician Organization, Partnership, Hospital, or Corporation (if applicable): _____

CIGNA HealthCare Provider Number (if applicable): _____

Tax Identification Number: _____

Address: _____

E-mail Address (optional): _____

SECTION II: ELECTION OF PAYMENT

Check one of the following boxes to make your election of payment.

☐ I direct the Settlement Administrator to pay directly to me my share of the Category A Settlement Fund.

☐ I direct the Settlement Administrator to contribute my share of the Category A Settlement Fund to the Foundation described above.

☐ I direct the Settlement Administrator to contribute my share of the Category A Settlement Fund to the foundation established by a Signatory Medical Society:

Name: _____

Address: _____

_____

_____

SECTION III: CERTIFICATION

Failure to sign this Certification will result in denial of your Proof of Claim.

I hereby certify the following:

1. I am a Member (or the legal representative of a Member) of the CIGNA Settlement Class. I did not Opt Out of the CIGNA Settlement Class.

2. Check one of the following:

   ☐ I am a Physician in active practice.

   ☐ I am a retired Physician who was in active practice on or after August 4, 1990.

   ☐ I am the legal representative of a Physician who was in active practice on or after August 4, 1990. I have attached documentation to confirm my status.

3. I have not submitted a Proof of Claim Form for Category One Compensation, Category Two Compensation or Medical Necessity Denial Compensation.

Name (Last, First, M.I.)	Signature
Date	Title (if applicable)

SECTION IV: AGREEMENT TO SUBMIT TO THE JURISDICTION OF THE COURT

By submitting a Proof of Claim, 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.

SECTION V: SUBMISSION OF PROOF OF CLAIM TO SETTLEMENT ADMINISTRATOR

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

Poorman-Douglas Corporation

[Address]

[Address]

Any request for payment from the Category A Settlement Fund postmarked after [_____] is not a Valid Proof of Claim and will be denied by the Settlement Administrator.

IF YOU HAVE QUESTIONS ABOUT THE FOUNDATION, THE CATEGORY A SETTLEMENT FUND, CATEGORY ONE COMPENSATION, CATEGORY TWO COMPENSATION, MEDICAL NECESSITY DENIAL COMPENSATION, OR ABOUT THE PROCEDURE FOR FILING A PROOF OF CLAIM, CONTACT THE SETTLEMENT ADMINISTRATOR AT [ ] OR CLASS COUNSEL AT [ ].

DO NOT CONTACT THE COURT WITH QUESTIONS ABOUT THE SETTLEMENT.