

Exclusion Request Form

Sutter Health Uninsured Pricing Cases, J.C.C.P. No. 4388

**I wish to opt out of this Settlement of the Sutter
Uninsured Pricing Cases.**

Date: _____, 2006

(signature)

(Please complete the following information)

Full Name

Street Address

City, State, zip code

Sutter Hospital(s) visited during Class period (Sept. 3, 2000 – Aug. 3, 2006)*

(*note: this information is optional, but providing it will help the Claims Administrator identify your records for exclusion from this Settlement.)

**If You Want to Exclude Yourself From The Settlement,
You Must Sign and Date This Form, Provide Your Address Information,
And Send It To The Following Address
By No Later Than October 26, 2006**

Settlement Administrator for
Sutter Health Uninsured Pricing Cases
Claims Administration Center
P.O. Box 38
Minneapolis, MN 55440

This is NOT a claim form.
If you submit this form, you will exclude yourself from the settlement,
and will receive no monetary refund or debt reduction