Class Member ID: 3104700000000

MUST BE POSTMARKED NO LATER THAN **MAY 24, 2019**

OPT OUT REQUEST FORM

Spinedex Physical Therapy USA, Inc., et al. v. United Healthcare of Arizona, Inc., et al
Case No. CV 08-0457-PHX-ROS

For Office Use Only

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF ARIZONA

DO NOT FILL OUT THIS FORM if you want to be included in this class action settlement and to receive any portion of the Settlement Fund to which you may be eligible if you do not opt out. If you do want to receive any portion of the Settlement Fund, you must complete the enclosed Claim Form and return it to the Settlement Administrator by mail on or before **May 24, 2019**.

INSTRUCTIONS

If you do not want to participate in the Settlement, you may "opt out" of the Settlement by returning this Opt-Out Request Form. If you choose to opt out of the Settlement: (a) you will have no right to receive any money under the Settlement; (b) you will not be bound by the Settlement; and (c) you will have no right to object to the Settlement and/or be heard at the final approval hearing. To opt out, you must sign and return this Opt-Out Request Form to the Settlement Administrator, at the address listed below, and you must mail it postmarked no later than **May 24, 2019** to:

Spinedex Class Action Litigation – EXCLUSIONS
c/o Settlement Administrator
PO Box 58430
Philadelphia, PA 19102-8430

OPT-OUT SIGNATURE

By signing this Opt-Out Request Form, I (or my company) hereby opt(s) out of the lawsuit and the Settlement. By signing this Opt-Out Request Form, I understand that I (or my company) will have no right to receive any money under the Settlement, and I (or my company) will have no right to object to the Settlement and/or be heard at the final approval hearing. If you are a medical provider, you must complete all of the information *and* the "Name of Medical Provider" line, and provide the last four digits of your Tax I.D. Number.

_____
Signature (under penalty of perjury)

_____ ___ ___ / ___ ___ / ___ ___ ___ ___
Name (Typed or Printed Name) *Date*

_____
Street Address

_____ _____ _____ _____ _____ _____
City *State* *Zip code*

_____
(Name of Medical Provider opting out if applicable)

(____ ____ ____) ____ ____ ____ -- ____ ____ ____ ____ ____ ____ ____ ____
Telephone number *Last 4 digits of SSN or Tax ID No.*

QUESTIONS? CALL TOLL FREE 1-844-702-2787
Please do not call the Court directly.