MAIL ID
0000PLACEHOLDER0000

Mohr, *et al.* v. The Trustees of The University of Pennsylvania as Owner and Operator of The University of Pennsylvania Health System (d/b/a Penn Medicine)
In the Court of Common Pleas of Philadelphia County
Case No. 230102149

Settlement Claim Form

If you are a Settlement Class Member and wish to receive a payment, your completed Claim Form must be postmarked on or before September 16, 2026, or submitted online on or before September 16, 2026.

Please read the full notice of this settlement (available at www.uphspixelsettlement.com) carefully before filling out this Claim Form.

To be eligible to receive any benefits from the settlement obtained in this class action lawsuit, you must submit this completed Claim Form online or by mail:

ONLINE: Submit this Claim Form.

MAIL: **UPHS Pixel Settlement Administrator, PO Box 4536, Portland, OR 97208-4536**

Did you receive a Unique ID by mail or email? The Unique ID is located on the front of the postcard notice or at the top of the email notice you may have received. Enter your Unique ID below:

PART ONE: CLAIMANT INFORMATION & PAYMENT METHOD ELECTION

Provide your name and contact information below. It is your responsibility to notify the Settlement Administrator of any changes to your contact information after the submission of your Claim Form. Also provide the Unique ID and PIN found in your email or mailed notice. If this information has been lost, please contact the Settlement Administrator at 1-877-327-7567 for assistance.

First Name | MI | Last Name

Street Address

City | State | ZIP Code

Email Address

Phone Number

POTENTIAL CASH PAYMENT: You may be entitled to receive a cash payment up to **$15.00** if between January 23, 2021, and January 23, 2023, you accessed the myPennMedicine patient portal and had a Pennsylvania address on file at the time of access.

The cash payment will be sent in the form of a check, unless otherwise indicated. If you would like payment in a different form, please select from the options below:

PAYMENT ELECTION

Please fill out **ONLY ONE** of the payment options below.

#1 Digital Payment Account – Payment Option

☐ PayPal ☐ Venmo ☐ Zelle

*Provide the email **OR** phone number, **NOT** both, associated with your selected digital payment account.*

Email Address

OR Phone Number

___ – ___ – ___

#2 Digital Card by Email – Payment Option

☐ Mastercard

Email Address for Delivery

#3 ACH Transfer: Direct Electronic Payment to a Bank Account – Payment Option

☐ Checking Account ☐ Savings Account

Routing Number

Account Number

#4 Physical Check or Mastercard to be Sent by Mail – Payment Option

Sent by mail to the address on this Claim.

☐ Physical Check ☐ Physical Mastercard

If you select more than one payment option, you will be mailed a check.

PART TWO: ATTESTATION UNDER PENALTY OF PERJURY

I declare under penalty of perjury under the laws of the United States of America that between January 23, 2021, to and through January 23, 2023, I accessed the myPennMedicine patient portal and had a Pennsylvania address on file at the time of access, and that all of the information on this Claim Form is true and correct to the best of my knowledge. I understand that my Claim Form may be subject to audit, verification, and Court review.

Signature

Date: MM – DD – YYYY

Please keep a copy of your Claim Form for your records.