Cote v. Wal-Mart Stores, Inc.
Claims Administrator
P.O. Box 43415
Providence, RI 02940-3415

WTE

Cote v. Wal-Mart Stores, Inc.,

Case No. 15-cv-12945-WGY (D. Mass.)

Must Be Postmarked No Later Than March 20, 2017

Long Form Claim

Submit This Long Form Claim To Receive A Payment Under This Settlement

Official Office Use Only

CLAIMANT INFORMATION

First Name | M.I. | Last Name

Primary Address

Primary Address Continued

City | State | Zip Code

Foreign Province | Foreign Postal Code | Foreign Country Name/Abbreviation

1. **Instructions**

a. If you wish to receive a payment and participate in the Settlement, **you must properly complete and return this Long Form Claim (or a Short Form Claim, listed before the Long Form Claim in the Notice packet)** (preferably in the enclosed postage-paid envelope). You may also return your Claim Form by faxing it to 877-839-2878, emailing it to WalmartSameSexSpouseBenefitsSettlement@kccllc.com or you may file electronically online at www.WalmartSameSexSpouseBenefitsSettlement.com.

b. To be considered timely, a Long Form Claim **must be postmarked on or before March 20, 2017 or faxed, emailed or filed electronically so that it is received on or before March 20, 2017**. You will have an additional 30 days to submit any documents, declaration(s), or statements to support your Long Form Claim, and therefore may submit such documentation by **April 18, 2017**.

c. To properly complete the Long Form Claim, you must provide the personal information requested below in Paragraph 2, and truthfully respond to the questions below in Paragraph 3 to determine your membership in the Settlement Class and the months for which you are eligible to receive compensation under the Settlement Agreement. **In addition, you must submit detailed documentation as requested in Paragraph 4 and attach any declaration(s), bills, statements, or other information to demonstrate your same-sex spouse's out-of-pocket Health Care Costs or the cost of purchasing a health insurance policy for your same-sex spouse during the Settlement Class Period.**

d. Any Claim Form that is not submitted by First Class Mail or the equivalent, or is postmarked or received by fax, email or filed electronically after **March 20, 2017**, is not addressed to the proper address, or is not signed and dated by the Settlement Class Member under penalty of perjury will **not** constitute a valid claim and may prevent you from receiving a payment under this Settlement. For more information on the Settlement and how your payment will be calculated, as well as your rights in connection with the Settlement, please see the attached Notice.

e. WE ENCOURAGE YOU TO MAKE A COPY OF THE SIGNED CLAIM FORM FOR YOUR RECORDS.

f. Changes of Address: It is *your responsibility* to keep a current address on file with the Claims Administrator. This is the address that will be used to mail your payment and tax forms. Please make sure to notify the Claims Administrator of any change of address.

g. If your same-sex spouse obtained spousal health insurance coverage through a Walmart-sponsored HMO plan during the Settlement Class Period (January 1, 2011 to December 31, 2013), you may not be eligible to receive a payment under the Settlement for the months during which such coverage was provided to your same-sex spouse. If you are unsure whether your same-sex spouse obtained spousal health insurance coverage through a Walmart-sponsored HMO plan during the Settlement Class Period, you should submit an inquiry through the Claims Administrator.

FOR CLAIMS PROCESSING ONLY	OB	CB	◯ DOC ◯ LC ◯ REV	◯ RED ◯ A ◯ B

h. If you have any questions about how to complete your Claim Form, or you have questions about whether or not you are eligible to submit a Claim Form in connection with this Settlement, you may contact the Claims Administrator or Class Counsel, whose contact information is provided in the Notice.

2. **Personal Information (please print)** (Note: Your personal information will be kept confidential by the parties and the Claims Administrator and used only for processing your payment and reporting tax information.)

Your name while a Walmart or Sam's Club associate (if different)

Current Email Address

Last 4 Digits of Social Security No.

Walmart Benefits ID Number (if known)

3. **Class Membership**

a. **Did you work at Walmart or Sam's Club between January 1, 2011 and December 31, 2013?**
(please fill in the circle) ◯ Yes ◯ No

If yes, please provide the approximate dates and location of your employment at Walmart or Sam's Club during that time period:

/ / to / /

Date employment began

Date employment ended

Location(s) where you worked (if more than one location, please include an attachment and list all others):

Address

City

State

Zip Code

b. **Were you married to a same-sex spouse at any point in time between January 1, 2011 and December 31, 2013?**
(please fill in the circle) ◯ Yes ◯ No

Name of Spouse

If yes, please provide the dates of your marriage to your same-sex spouse:

/ / to / /

Date of marriage

End date of marriage (if still married write today's date or "Present")

4. **Documenting the Out-of-Pocket Health Care Costs of Your Same-Sex Spouse or the Cost of Purchasing a Health Insurance Policy for Your Same-Sex Spouse**

a. **To receive a payment for a Long Form Claim, you must provide documentation of** (1) the out-of-pocket Health Care Costs your same-sex spouse was charged (but which were not forgiven by a medical provider) during the Settlement Class Period (January 1, 2011 to December 31, 2013), including any medical, dental or vision costs, **and/or** (2) the cost that was actually paid to purchase a health insurance policy for your same-sex spouse from an entity other than Walmart during the Settlement Class Period (January 1, 2011 to December 31, 2013). You can provide documentation of out-of-pocket Health Care Costs *and* the cost of purchasing a health insurance policy during the Settlement Class Period, but you cannot receive a payment for both types of costs for *the same* month(s) during the Settlement Class Period.

b. If you are submitting documentation of out-of-pocket Health Care Costs of your same-sex spouse, please provide the following information.

Describe generally the types of out-of-pocket Health Care Costs for which you are seeking reimbursement. ***Please note that if the out-of-pocket Health Care Costs for which you are seeking reimbursement would not have been covered under a Walmart-sponsored Health Insurance Policy, you will not receive a payment for reimbursement of those costs. A list of excluded health care services can be found on the Claims Administrator's web site at www.WalmartSameSexSpouseBenefitsSettlement.com.***

Approximately what months were the health care services provided in the following years of the Settlement Class Period?

____ 2011

____ 2012

____ 2013

How much were the total charges for out-of-pocket Health Care Costs?

$ | | | | | | | |

Please confirm that the out-of-pocket Health Care Costs you are seeking reimbursement for have NOT been forgiven by the medical provider.

(please fill in the circle) ◯ Yes, the costs have NOT been forgiven.

◯ No, some or all of the costs HAVE been forgiven

If NO, what portion of the total charges were forgiven

$ | | | | | | | |

Please confirm that the out-of-pocket Health Care Costs for which you are seeking reimbursement relate to medical, vision, or dental services that were provided during month(s) in which your spouse was NOT enrolled in any medical Health Insurance Plan.

(please fill in the circle) ◯ Yes, the costs were charged for services in months when my spouse was NOT enrolled in any medical Health Insurance Plan

◯ No, the costs were charged for services in months when my spouse WAS enrolled in a medical Health Insurance Plan

If NO, please state the months your same-sex spouse WAS enrolled in a medical Health Insurance Plan during the Settlement Class Period:

____ 2011

____ 2012

____ 2013

c. *If you are submitting documentation of the cost of purchasing a health insurance policy for your same-sex spouse, please provide the following information.*

What months was your same-sex spouse covered by the alternative health insurance policy or policies during the Settlement Class Period?

____ 2011

____ 2012

____ 2013

How much did you or your spouse actually pay to purchase the alternative health insurance policy or policies in each year of the Settlement Class Period?

$ | | | | | | | | 2011

$ | | | | | | | | 2012

$ | | | | | | | | 2013

d. *In an attachment to this Long Form Claim, please provide any and all documentation of the out-of-pocket Health Care Costs of your same-sex spouse or the cost of purchasing a health insurance policy for your same-sex spouse during the Settlement Class Period. Such documentation may include* any declaration(s), bills, statements, or other information to demonstrate your same-sex spouse's out-of-pocket Health Care Costs or the cost of purchasing a health insurance policy for your same-sex spouse. Your Long Form Claim cannot be processed without this information, which must be received no later than April 18, 2017.

5. **Determination by the Claims Administrator**

After your Long Form Claim is submitted, the Claims Administrator will make a determination about the amount of your out-of-pocket Health Care Costs or cost of purchasing a health insurance policy that will be accepted for the purpose of the payment that you may be entitled to receive under the Settlement. After the determination is made, you will receive a copy of the Claims Administrator's determination of your Long Form Claim, and you then will have an opportunity to ask the Claims Administrator to reconsider its determination by describing why the determination should be modified. Upon a showing of good cause for reconsidering the determination, the Claims Administrator may modify the determination.

6. **No Assignment of Claims**

By signing below, I verify that I have not assigned any of the claims described above.

7. **Medical Liens**

By signing below, I verify that I am not subject to any medical liens arising out of any claims that are the subject of this Settlement. (If you are subject to any medical liens, please contact the Claims Administrator)

8. **Authorization to Disclose Protected Health Information**

By signing below, I provide my authorization to the Claims Administrator, Class Counsel, and Walmart's counsel to receive the information requested by this Claim Form, including any information that may be protected health information. Any personal information that I provide through this Claim Form shall be treated as confidential and shall be handled pursuant to the Protective Order approved by the Court in this case.

9. **Signature**

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

Signature: ____ Dated: ______________________________

Print Name: ____

SEND TO THE CLAIMS ADMINISTRATOR AT:

Cote v. Wal-Mart Stores, Inc. Claims Administrator
P.O. Box 43415
Providence, RI 02940-3415
Fax: 1-877-839-2878
Email: WalmartSameSexSpouseBenefitsSettlement@kccllc.com

THIS FORM MUST BE MAILED BY U.S. FIRST CLASS MAIL, POSTMARKED OR RECEIVED
BY FAX, EMAIL OR FILED ELECTRONICALLY NO LATER THAN:
March 20, 2017.

ANY SUPPORTING DOCUMENTATION TO SUPPORT YOUR LONG FORM CLAIM MUST BE MAILED BY U.S. FIRST CLASS MAIL, POSTMARKED OR RECEIVED BY FAX, EMAIL OR UPLOADED TO THE SETTLEMENT WEBSITE NO LATER THAN:
April 18, 2017.

KEEP A COPY OF THIS FORM FOR YOUR RECORDS.
YOU MAY WISH TO REQUEST A RETURN RECEIPT FROM THE POST OFFICE.