

Teblum v. Physician Compassionate Care LLC
d/b/a DocMJ Settlement Administrator
P.O. Box 43502
Providence, RI 02940-3502



PYE

*Teblum v. Physician Compassionate
Care LLC d/b/a DocMJ*

UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF FLORIDA

Case No. 2:19-cv-00403-SPC-MRM

**Must Be Postmarked
No Later Than
August 27, 2022**

Settlement Claim Form

Return this Claim Form to: *Teblum v. Physician Compassionate Care LLC d/b/a DocMJ* Settlement Administrator,
P.O. Box 43502, Providence, RI 02940-3502. Questions, visit www.PhysicianCompassionateCareTCPASettlement.com
or call 1-844-917-2017.

DEADLINE: THIS CLAIM FORM MUST BE FULLY COMPLETED, BE SIGNED UNDER OATH, AND MEET ALL CONDITIONS OF THE SETTLEMENT AGREEMENT. THIS CLAIM FORM CAN BE SUBMITTED BY U.S. MAIL BUT MUST BE POSTMARKED ON OR BEFORE 8/27/2022. THIS CLAIM FORM CAN BE SUBMITTED VIA EMAIL AT INFO@PHYSICIANCOMPASSIONATECARETCPASETTLEMENT.COM OR ONLINE AT WWW.PHYSICIANCOMPASSIONATECARETCPASETTLEMENT.COM BUT MUST BE SUBMITTED NO LATER THAN 11:59 P.M. EASTERN ON 8/27/2022.

YOU MUST SUBMIT THIS CLAIM FORM TO RECEIVE A SETTLEMENT PAYMENT.

Please note that if you are a Class Member, the Class Member Verification section below requires you to state, under penalty of perjury, that all information contained therein is true and correct. This Claim Form may be researched and verified by the Settlement Administrator.

| | | |
|--|---|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| First Name | M.I. | Last Name |
| <input type="text"/> | | |
| Primary Address | | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| City | State | ZIP Code |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Telephone Number on the Date you Received a Text Message | | |
| <input type="text"/> | | |
| Email Address | | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Current Phone Number | or <input type="radio"/> fill in if same as above | |
| (Please provide a phone number where you can be reached if further information is required.) | | |
| <input type="text"/> | | |
| Claim ID | | |



| | | | | |
|----------------------------------|-------------------------|-------------------------|--|---|
| FOR CLAIMS PROCESSING ONLY | OB <input type="text"/> | CB <input type="text"/> | <input type="radio"/> DOC <input type="radio"/> LC <input type="radio"/> REV | <input type="radio"/> RED <input type="radio"/> A <input type="radio"/> B |
|----------------------------------|-------------------------|-------------------------|--|---|

By submitting this Claim Form, I declare under penalty of perjury that I am a member of the Class defined as: "All persons within the United States (1) who were sent a text message; (2) by or on behalf of Defendant; (3) on their mobile telephone; (4) from June 14, 2015 through the date of final approval; (5) using the text messaging platform provided by Twilio to send text messages like the one that Plaintiff received." I further declare under penalty of perjury that I am the current subscriber of the cellular telephone mentioned in subsection (ii) above, and that the information provided herein is true and correct.

Additional information regarding the Settlement can be found at www.PhysicianCompassionateCareTCPAsettlement.com.

I declare under penalty of perjury that the foregoing is true and correct.

Signature: _____

Dated (mm/dd/yyyy): _____

Print Name: _____

If you have questions, you may call the Settlement Administrator at 1-844-917-2017.

