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CLAIM FORM – Pressman, Inc., et al. v. Smith Medical Partners, LLC, et al., Case No. 19-cv-1723

Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___

*You must complete all **THREE** steps below to claim a share of the Settlement Fund:*

1. You must provide your contact information.

Name: _____

Company: _____

Address: _____

City/State/Zip Code: _____

Telephone Number: _____ Email Address: _____

Fax Numbers (list or attach a listing of all fax numbers you or your company had or used at any time from September 26, 2013 through January 16, 2019):

(___ ___ ___) ___ ___ ___ - ___ ___ ___ , (___ ___ ___) ___ ___ ___ - ___ ___ ___

(___ ___ ___) ___ ___ ___ - ___ ___ ___ , (___ ___ ___) ___ ___ ___ - ___ ___ ___

2. You must verify that you used or owned the fax numbers you’ve identified above, but you do not need to remember receiving any faxes from Smith.

“At least ONE of the following things was true sometime during the period September 26, 2013 through January 25, 2019:

- a. The fax number(s) listed above was/were mine or my company’s; **or**
- b. I used the fax number(s) listed above, or my company used the fax number(s) listed above; **or**
- c. I received facsimiles at the fax number(s) listed above, or my company received facsimiles at the fax number(s) listed above.”

(Sign your name here)

3. You must return this Claim Form by November 16, 2020:

a. Fax this Claim Form to: 215-240-6313

OR

b. Mail this Claim Form to:

Pressman v. Smith Medical Partners, LLC
PO Box 8796
Philadelphia, PA 19101-8796

OR

c. Complete and submit this Claim Form electronically at: smithtcpafaxsettlement.com