

THIRD-PARTY PAYOR CLAIM FORM

YOUR CLAIM MUST BE POSTMARKED OR SUBMITTED ONLINE ON OR BEFORE **APRIL 17, 2025**.

Submit the Claim Form at the Settlement website, www.SavingsClubSettlement.com, OR

Mail your claim to: *In re Walgreens Savings Club Litigation Settlement*, c/o A.B. Data, Ltd., P.O. Box 173067, Milwaukee, WI 53217.

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT ON BEHALF OF A THIRD-PARTY PAYOR (“TPP”) CLASS MEMBER (OR AN AUTHORIZED AGENT) AND NOT BY INDIVIDUALS. A Claim Form for Individuals is available at www.SavingsClubSettlement.com.

PART I – CLAIMANT IDENTIFICATION

- Complete Section A if you are filing as a TPP Class Member on behalf of your own company.
- Complete Section B if you are an authorized agent filing on behalf of one of more TPP Class Members.

Section A: Company or Health Plan TPP Class Member

Company or Health Plan Name

Contact Name

Address 1

Address 2

City

State

Zip

Area Code – Telephone Number

Tax Identification Number

Email Address

Claim Identification Number (if provided by Settlement Administrator)

List other names by which your company or health plan has been known or other Federal Employer Identification Numbers (“FEINs”) it has used since January 1, 2007.

Health Plan Type: (Select one)

- Health Insurance Company/HMO Self-Insured Employee Health Plan Self-Insured Health & Welfare Fund
- Other (Explain)

Section B: Authorized Agent Only

** As an Authorized Agent, please indicate how your relationship with the TPP Class Member(s) is best described: (Select one)

- Third-Party Administrator
- Pharmacy Benefit Manager
- Other (Explain)

Authorized Agent's Company Name

Contact Name

Address 1

Address 2

City

State

Zip

Area Code – Telephone Number

Authorized Agent's Tax Identification Number

Email Address

List the name and FEIN of every TPP Class Member (*i.e.*, Company or Health Plan) for whom you have been duly authorized to submit this Claim Form (attach additional sheets to this Proof of Claim as necessary). Alternatively, you may submit the information for Section A and B for each TPP Class Member in an electronic format, such as Excel or a tab-delimited text file saved on a disk or flash drive. Please contact the Settlement Administrator to determine what formats are acceptable.

TPP CLASS MEMBER'S NAME

TPP CLASS MEMBER'S FEIN

PART II – AMOUNT CLAIMED

Please type or print in the box below, the total amount paid by each TPP Class Member for one or more prescription drugs from Walgreens,¹ where prescription insurance benefits were used in filling the prescription(s), at any time from January 1, 2007 through November 18, 2024, for which the TPP Class Member was not reimbursed from any source. This amount should not include any amounts the TPP Class Member’s beneficiaries paid to Walgreens, including any co-pays, deductibles, and/or co-insurance.

TPP CLASS MEMBER’S NAME	TOTAL AMOUNT PAID FOR PRESCRIPTION DRUGS

Please note that certain groups have been excluded from the Class in this case. Do not submit a claim for or on behalf of any of the following excluded groups: (a) Walgreens and its management and affiliates, and employees of Walgreens and its affiliates; (b) the Court, members of their immediate families, and judicial staff (but not members of the immediate families of judicial staff); (c) all pharmacy benefit managers; (d) individuals who paid for all of their prescription drugs from Walgreens from January 1, 2007 through November 18, 2024, without using insurance benefits; (e) federal and state government entities other than government-funded employee benefit plans; and (f) all individuals and entities, except for the named plaintiffs, that have sued, filed an arbitration demand, or participated in a settlement in a suit against Walgreens relating to its determination of usual and customary prices in connection with the Prescription Savings Club (this exception to the exclusion from the Settlement Class does not apply to individuals or entities that have voluntarily dismissed their claims without prejudice in any suit or arbitration). Also, if the TPP Class Member excluded themselves from the Settlement Class, you may not file a claim on their behalf.

Proof of Payment

You must submit claims data and information in support of the purchase amounts stated above. Instructions on how to do so are found in the Claims Documentation Requirements Section within the Third-Party Payor Claim Form Instructions on the Settlement website. The Settlement Administrator may require additional supporting documentation after reviewing your claim.

¹ Walgreens includes all pharmacies owned and operated by Walgreen Co., or any of its affiliates, but only to the extent and for the time period they accepted Walgreens’ Prescription Savings Club during the Settlement Class Period.

PART III – CERTIFICATION

I have read and am familiar with the contents of this Claim Form. I certify that the information I have set forth above and in any documents attached by me are true, correct, and complete to the best of my knowledge. I certify that I, or the TPP Class Member(s) I represent, paid the total amount set forth above in expenditures for purchases for one or more prescription drugs from Walgreens, where prescription insurance benefits were used in filling the prescription(s), at any time from January 1, 2007 through November 18, 2024, and that this amount is net of any amounts a TPP Class Member’s beneficiaries paid to Walgreens, including any co-pays, deductibles, and co-insurance. I further certify that I, or the Class Member(s) I represent, did not opt out of the Settlement Class in this Action.

In addition: (a) I am not (or the represented TPP Class Member(s) is/are not) a member of Walgreens or any Walgreens affiliates’ management, nor am I (or is the represented TPP Class Member) an employee of Walgreens and its affiliates; (b) I am not (or the represented TPP Class Member(s) is/are not) the Court, nor am I (or is/are the represented TPP Class Member(s)) a member of the Court’s immediate family, or a member of the Court’s judicial staff; (c) I am not (or the represented TPP Class Member(s) is/are not) a pharmacy benefit manager; (d) all prescriptions submitted with this Claim (or these Claims) were paid for or reimbursed in conjunction with prescription drugs purchased from Walgreens from January 1, 2007 through November 18, 2024, and in which prescription insurance benefits were used in filling the prescription(s); (e) I am not (or the represented TPP Class Member(s) is/are not) a federal or state government entity other than government-funded employee benefit plan; and (f) with the exception of individuals or entities that have voluntarily dismissed their claims without prejudice in any suit or arbitration, I am not (or the represented TPP Class Member(s) is/are not) an individual or entity, except for the named plaintiffs, that has sued, filed an arbitration demand, or participated in a settlement in a suit against Walgreens relating to its determination of usual and customary prices in connection with the Prescription Savings Club.

To the extent I have been given authority to submit this Claim Form by a TPP Class Member(s) on its/their behalf, and accordingly am submitting this Claim Form in the capacity of an Authorized Agent with authority to submit it by the TPP Class Member(s) identified above and submitted with this form, I also have been authorized to receive payment on behalf of this TPP Class Member(s). In the event amounts from the Settlement Fund are distributed to me or my employer and a TPP Class Member(s) I purport to represent later claims that I did not have authority to claim and/or receive such amounts on its/their behalf, I and/or my employer will hold the TPP Settlement Class, counsel for the Settlement Class, and the Settlement Administrator harmless with respect to any claims made by the TPP Class Member(s).

I, and the TPP Class Member(s) for which I have been given authority to submit this Claim Form, hereby submit to the jurisdiction of the United States District Court for the Northern District of Illinois for all purposes connected with this Claim Form, including resolution of disputes relating to this Claim Form. I acknowledge that any false information or representations contained herein may subject me to sanctions, including the possibility of criminal prosecution. I agree to supplement this Claim Form by providing documents as proof for the information I provided herein, upon request of the Settlement Administrator.

I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Claim Form was executed this _____ day of _____ 202_.

Signature

Position/Title

Print Name

Date

Authorized Agent Signature

Position/Title

Print Name

Date

If you did not complete this Claim Form online and submit it electronically through the Settlement website, you must mail your completed Claim Form with any supporting documents, postmarked on or before **April 17, 2025**, to the following address:

In re Walgreens Savings Club Litigation
c/o A.B. Data, Ltd.
P.O. Box 173067
Milwaukee, WI 53217

Toll-Free Telephone: **1-877-888-8386**

Website: www.SavingsClubSettlement.com

REMINDER CHECKLIST:

1. Please complete, sign, and mail the above Claim Form or complete the online Claim Form. Attach or upload any documentation supporting your claim.
2. Keep a copy of your Claim Form and supporting documentation for your records.
3. If you would like acknowledgement of receipt of your Claim Form, please complete the form online or mail this form via Certified Mail, Return Receipt Requested.
4. If the company you work for and/or the TPP Class Member(s) for which you have been given authority to submit this Claim Form moves or changes its name, please send the new address and/or new name or contact information to the Settlement Administrator at info@SavingsClubSettlement.com or via U.S. Mail at the address above.