

ELIGIBLE PERSON INFORMATION

I declare under penalty of perjury under the laws of the State of Washington that the information supplied in this Claim Form is true and correct to the best of my knowledge and that this Claim Form was executed on the date set forth below.

I declare that I have sought health care from Polyclinic between January 1, 2021, and September 30, 2025.

I further declare that I have had an opportunity to review this Notice of Settlement and Claim Form with an attorney of my choosing, at my own cost, and that I was provided with multiple methods to review the Notice of Settlement and Claim Form, including the opportunity to receive a Braille version of the documents if a sight impairment prevented me from reading the text version; access to a video with a certified American Sign Language interpreter summarizing the documents; and an audio recording summarizing the Notice of Settlement and Claim Form.

Full Legal Name

Date of Birth

Signature

Date Signed

Address

Phone (VRS number if preferred)

City State Zip

Email (optional)

Social Security Number

Additional Methods of Communication (optional)

If your address or contact information changes, you must update the Settlement Administrator as soon as possible to ensure you receive your payment.