MA9 Settlement Administrator
P.O. Box 301134
Los Angeles, CA 90030-1134

MA9

VISIT THE SETTLEMENT WEBSITE BY
SCANNING THE PROVIDED QR CODE

John Doe I, John Doe II, and John Doe III v. MarinHealth Medical Center
MARIN COUNTY SUPERIOR COURT
Case No. CV-000-2218

Must Be Postmarked
By September 24, 2025

CLAIM FOR MARINHEALTH META PIXEL LITIGATION SETTLEMENT BENEFITS

USE THIS FORM TO MAKE A CLAIM FOR A PRO RATA CASH FUND PAYMENT

Para una notificación en Español, llamar 1-833-422-2622 o visitar nuestro sitio web www.MarinHealthSettlement.com.

The DEADLINE to submit this Claim Form is: September 24, 2025

I. WHAT YOU MAY GET - GENERAL INSTRUCTIONS

If you are a Marin Medical Center patient, California citizen, or a member of the public, who visited MarinHealth Medical Center's Websites between August 1, 2019, through May 27, 2025, you are a Class Member.

As a Class Member, you are eligible to make a claim for a Settlement Payment:

A pro rata Cash Fund Payment (equal payment paid to all Participating Settlement Class Members who submit a timely and valid Claim Form) to be paid for from the Net Settlement Fund, the amount of which will depend on the number of Class Members who participate in the Settlement.

Cash Settlement Payment amounts may be reduced or increased pro rata (equal share) depending on how many Class Members submit claims. Complete information about the Settlement and its benefits are available at www.MarinHealthSettlement.com.

This Claim Form must be submitted online at www.MarinHealthSettlement.com or completed and mailed to the address below. Please type or legibly print all requested information, in blue or black ink. Mail your completed Claim Form, including any supporting documentation, by U.S. mail to:

MA9 Settlement Administrator
P.O. Box 301134
Los Angeles, CA 90030-1134
admin@MarinHealthSettlement.com

Please note: the Settlement Administrator may contact you to request additional documents to process your claim. Your cash benefit may decrease depending on the number and amount of claims submitted.

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

II. CLAIMANT INFORMATION

The Settlement Administrator will use this information for all communications regarding this Claim Form and the Settlement. If this information changes prior to distribution of cash Settlement Payments, you must notify the Settlement Administrator in writing at the address above.

First Name M.I. Last Name

Primary Address

Primary Address Continued

City State ZIP Code

Email Address

— —

Area Code Telephone Number

Claim ID (Located on the Notice mailed to you, if known)

III. REQUEST FOR CASH PAYMENT

Cash Fund Payment. You do not need to submit any additional documents, so long as you provide your Claim ID Number that was provided on your mailed Notice. A check will be mailed to the address you provided in Section II, above.

If you would prefer to receive your Settlement Payment via PayPal or Venmo, please file your claim online at www.MarinHealthSettlement.com.

Signature: _____ Dated (mm/dd/yyyy): _____

Print Name: _____

Questions? Visit www.MarinHealthSettlement.com or call 1-833-422-2622.

THIS CLAIM FORM MUST BE SUBMITTED OR POSTMARKED BY SEPTEMBER 24, 2025 IN ORDER TO BE TIMELY AND VALID.