CLAIM FORM

Mara Berton v. Aetna Inc. & Aetna Life Insurance Company
U.S. District Court, Northern District of California
Case No. 4:23-cv-01849 (HSG)

CATEGORY D-A CLASS MEMBERS MUST COMPLETE AND RETURN THIS FORM SO IT IS POSTMARKED OR SUBMITTED ONLINE BY JUNE 29, 2026 TO BE PART OF THE CLASS AND BE ELIGIBLE FOR ANY PAYMENT FROM THIS SETTLEMENT

COMPLETION AND SUBMISSION OF THIS FORM IS NOT GUARANTEE OF ELIGIBILITY.

GENERAL CLAIM SUBMISSION FORM INFORMATION

- Failure to fully complete a claim may result in an ineligible claim. After you submit your claim, if additional information is required to complete your claim, you will be notified by mail and/or email.
- To get the documentation you need, you may need to request your medical records and billing records from your fertility treatment provider(s).
- Any documents submitted as supporting evidence will not be returned. Please retain copies of your documents for your own records.
- This form will be maintained as confidential until the case has concluded, and then it will be destroyed. [1]

YOU ARE HIGHLY ENCOURAGED TO SUBMIT THIS FORM ONLINE AT:

www.CaliforniaInfertilitySettlement.com

The platform is safe and secure for submitting health-related information.

Alternatives to Submitting Online:

Mail	*Email*	*Fax*
California LGBTQ+ Fertility Coverage Settlement c/o Atticus Administration PO Box 64053 Saint Paul, MN 55164	***CaliforniaInfertilitySettlement@atticusadmin.com***	**1-888-326-6411**

[1] This form will be used for no purpose other than this litigation and the administration of the settlement. Limited Aetna personnel will review the medical history information provided only as necessary to process Class Members' claims. This form and its contents will not be disclosed to anyone else except Class Counsel, Defendants' Counsel, the Administrator, and the Court under seal.

PLEASE READ THIS CLAIM SUBMISSION FORM AND THE ENCLOSED SETTLEMENT NOTICE CAREFULLY

Step 1: Class Member Information - REQUIRED

Class Member First Name | **Class Member Last Name** | **M.I.**

Aetna Member Number (W Number): | **Social Security Number:**

Employer/ Plan Sponsor: | **Date of Birth (mm/dd/yyyy):**

If the address on page one is correct check here: ☐

If the address on page one is not correct, or if none is listed, provide info below:

Class Member Address

City | **State** | **Zip Code**

Class Member Email Address: | **Class Member Telephone:** | **Pick One:** Mobile ☐ Home ☐

Are you acting on behalf of a deceased or incapacitated Class Member? **NO** ☐ **YES** ☐

If you are acting on behalf of a deceased Class Member or a Class Member who does not have the capacity to act on their own behalf, documentation supporting your authority to act on their behalf will be required to validate your claim. To proceed, please complete the representative portion of the claim below and submit documentation substantiating your authority to act on behalf of the above Class Member.

FOR SURVIVORS/REPRESENTATIVES OF CLASS MEMBERS ONLY

Representative First Name	Representative Last Name	M.I.

Representative Address

City	State	Zip Code

Representative Email Address:	Representative Telephone:	Pick One:
		Mobile ☐ Home ☐

ATTESTATION - REQUIRED

At the time you sought coverage for or received artificial insemination services while you were on an Aetna plan, were you in an Eligible LGBTQ+ Relationship as defined in the Notice?

☐ Yes ☐ No

STEP 2: Artificial Insemination History Between 4/17/19 and 12/31/24 – REQUIRED

____ *I am seeking the Default Payments.*

- ***Fill out Chart A Only: Artificial Insemination History: Eligibility***

____ *I am seeking a higher payment.*

- ***Skip Chart A and Fill out Chart B: Artificial Insemination History: Seeking Higher Payment***

A. ARTIFICAL INSEMINATION HISTORY: ELIGIBILTY

Provide the requested information and documentation for at least **one IUI or ICI cycle** you paid for out-of-pocket *and have not been reimbursed for by insurance* between 4/17/19 and 12/31/24.

B. ARTIFICAL INSEMINATION HISTORY: SEEKING HIGHER PAYMENT

Provide the requested information and documentation for **all IUI or ICI cycles** you paid for out-of-pocket between 4/17/19 and 12/31/24 *and have not been reimbursed for by insurance*. If you run out of space, you may provide additional information in a separate document.

Date of Service	**Services Received (check all that apply)**	**Provider Name & Address**	**Documentation Attached?**
	__ Menotropin (S4035) __ IUI (58322) __ ICI (58321)		__ Yes ___ No
	__ Menotropin (S4035) __ IUI (58322) __ ICI (58321)		__ Yes ___ No
	__ Menotropin (S4035) __ IUI (58322) __ ICI (58321)		__ Yes ___ No
	__ Menotropin (S4035) __ IUI (58322) __ ICI (58321)		__ Yes ___ No
	__ Menotropin (S4035) __ IUI (58322) __ ICI (58321)		__ Yes ___ No
	__ Menotropin (S4035) __ IUI (58322) __ ICI (58321)		__ Yes ___ No
	__ Menotropin (S4035) __ IUI (58322) __ ICI (58321)		__ Yes ___ No
	__ Menotropin (S4035) __ IUI (58322) __ ICI (58321)		__ Yes ___ No
	__ Menotropin (S4035) __ IUI (58322) __ ICI (58321)		__ Yes ___ No

STEP 4: Documentation - REQUIRED

As noted above, you MUST provide the required supporting evidence to support the procedure(s) described in **STEP 3**. Examples of acceptable forms for supporting evidence might include a bill from your provider, a medical record or a self-pay agreement. Evidence provided must, at a minimum, confirm (1) that you received a service, (2) what service you received, (3) the date of service and (4) that you were billed for that service.

STEP 5: SPECIAL HARMS SUBMISSION – OPTIONAL

Fill out this section if you are seeking additional money because you paid over $11,408 out-of-pocket or suffered other harm. If you are not seeking additional money, skip to STEP 6.

A. OUT-OF-POCKET EXPENSES/ECONOMIC LOSS

The Special Harms Fund is available to compensate people for expenses and losses that exceed their Default or Pro Rata Payment plus their Dollars for Benefits Payment. To get compensation, the expenses/losses must be because of Aetna's allegedly discriminatory policy. Examples of potentially eligible expenses include:

- Costs or economic losses that you incurred because you underwent IUI cycles to meet Aetna's requirements to be considered infertile that you would not have otherwise undergone, including costs associated with associated medications, monitoring visits, purchases of donor sperm, and delivery and storage of donor sperm;
- Wages lost because you went to fertility treatment appointments you would not have gone to if you weren't trying to meet Aetna's requirements to be considered infertile;
- Interest on debts you could not pay down because you needed to pay for fertility procedures out-of-pocket; and
- IVF costs if your plan covered IVF but you were denied coverage because of Aetna's allegedly discriminatory policy.

Are you applying for compensation for out-of-pocket costs or economic losses in excess of $11,408?

___ **No: Skip to B.**

__ **Yes**: Complete the following and attach supporting documentation:

Expense Amount and Date	Description of Expense and Support Documents *Identify the expense, what documentation you are providing in evidence of the expense, and how the expense is associated with Aetna's denial or anticipated denial of your infertility benefits.*
$ Date:	
$ Date:	
$ Date:	

B. SPECIAL HARMS

The Special Harms Fund is available to compensate Class Members who suffered harms that did not affect all Class Members. Examples of special harms you may be able to get compensation for include:

- Circumstances such as a history of sexual assault, abuse, or pregnancy loss rendering fertility procedures especially difficult or traumatic;
- Extreme delay or total loss of the ability to parent due to Aetna's challenged policy;
- Pain and suffering, medical complications, and/or miscarriage associated with having to undergo fertility procedures you underwent to meet Aetna's requirements to be considered infertile **that you otherwise would not have undergone.**

If you are seeking additional compensation for harms that did not affect all Class Members, please answer the questions below. You may provide this information in another document if you run out of space.

1. Did you undergo any medical procedures to try to meet Aetna's Definition of Infertility that you would not have otherwise undergone? If so, please describe the procedures and any pain, suffering, or medical complications that you experienced as a result.

2. Did you experience extreme delay in receiving fertility treatment as a result of Aetna's denial of coverage or anticipated denial of coverage? Please explain why and explain any negative effects you believe the delay had on you medically, including with respect to your ability to become pregnant or carry a pregnancy to term.

3. Is there anything else you would like to share about what happened to you following the denial or anticipated denial of infertility coverage?

PROVIDE AS MUCH DOCUMENTATION AS YOU CAN TO SUPPORT YOUR CLAIM. Any supporting documentation provided will not be returned. Please retain copies of your documents for your own records. You will be notified by mail and/or email if anything additional is needed for your Special Harm Submission. Please make sure the Settlement Administrator has your current mail and email addresses.

STEP 6: CERTIFICATION

I declare under penalty of perjury under the laws of the State of California and the United States that the medical procedure history and financial information included in this form and the accompanying supporting evidence are true and correct to the best of my knowledge.

Signature

Date