



for official use only



Must be
Postmarked By
August 10, 2009

Simonet

v.

SmithKlineBeecham, D.P.R., No. 06-cv-1230

THIRD-PARTY PAYOR CLAIM FORM

The information you provide will be kept confidential and will be used only for administering this settlement. If you have any questions, please call the Claims Administrator at 1-866-458-3186.

The Proposed Settlement includes a third-party payor ("TPP") Class that consists of all entities in the United States and its territories (other than Medicaid, Medicare and other federally-funded government healthcare programs) that purchased, paid for or reimbursed for (in whole or in part) Paxil CR® between April 1, 2002 and March 4, 2005.

A TPP Class member or an authorized agent can complete this Claim Form. If both a Class member and its authorized agent submit a Claim Form, the Claims Administrator will only consider the Class member's Claim Form. The Claims Administrator may request supporting documentation. The claim may be rejected if any requested documentation is not provided.

If one or more Class members has authorized you to submit a Claim Form on its behalf, you must provide the information requested in Section B in addition to the other information requested by this Claim Form. You may submit a separate Claim Form for each Class member that has duly authorized you to do so, OR you may submit one Claim Form for all such Class members that have authorized you to do so, as long as you provide the information required (as indicated below) for each Class member on whose behalf you are submitting the form.

If you are submitting Claim Forms both on your own behalf as a Class member AND on behalf of one or more Class members that have authorized you to do so, you should submit one Claim Form for yourself and another Claim Form or Forms for the other Class member(s). **Do not submit a Claim Form on behalf of any Class member without obtaining and providing specific prior authorization from that Class member.**

SECTION A – CLAIMANT IDENTIFICATION

Please indicate whether you are claiming on your own behalf as a Class member or as the authorized agent of one or more Class members by placing an "X" in the appropriate space below. If you wish to make a claim as a Class member *and also* as the authorized agent of other Class members, please complete one Claim Form for your claim as a Class member and a separate Claim Form for those Class members for whom you are authorized to submit a claim:

I am the Class member

I am filing as the authorized agent of a Class member**

** As Authorized Agent, please check how your relationship with the Class member is best described:

Third Party Administrator (other than a Pharmacy Benefits Manager)

Pharmacy Benefits Manager

Other (Explain):





SECTION B – CLASS MEMBER OR AGENT INFORMATION

Class Member's/Authorized Agent's Name

Street Address

Floor/Suite

City

State

Zip Code

Area Code – Telephone Number

Area Code – Fax Number

Class Member's/Authorized Agent's Tax Identification Number

If you file as a Class member, list other names by which you have been known or other Federal Employer Identification Numbers ("FEINs") you have used from January 1, 1998 through December 31, 2004.

Names:

FEINs:

If you are filing as the Class member, check the term below that best describes your company/entity:

Health Insurance Company/HMO

Self-Insured Employee Health Plan

Self-Insured Union Health & Welfare Fund

Other (Explain): _____

SECTION C – CLAIM BY AUTHORIZED AGENT

Please list the Federal Employer Identification Number and the name of every Class member for whom you have been duly authorized to submit this Claim Form (attach additional sheets to this Claim Form as necessary). Alternatively, you may submit the requested list of Class member names and FEINs in an acceptable electronic format. Please contact the Claims Administrator to determine what formats are acceptable.

SECTION D – CLAIM FOR PAXIL CR® DRUG REIMBURSEMENTS

For each Class member on whose behalf you are submitting a claim, state the number of covered lives as of December 31, 2004. If necessary, please duplicate this section so that you use it once for each Class member on whose behalf you are submitting a claim.

Current Name of Class Member :

Number of Covered Lives as of December 31, 2004:

Claimant truthfully attests, under penalty of perjury, that the above-named class member purchased, paid for or reimbursed for (in whole or part) Paxil CR® tablets on at least one occasion between April 1, 2002 and March 4, 2005.





Claimant certifies that the covered lives figures submitted herein are true and accurate and are based upon actual records maintained by or otherwise available to the claimant.

Signature

Position

Print Name

Month/Day/Year

SECTION E – JURISDICTION OF THE COURT AND CERTIFICATION

Please duplicate this section and submit it for each TPP Class member on whose behalf you are submitting a claim.

By signing below, I hereby swear and affirm under penalty of perjury that the following is correct: (1) I have authority to submit this Claim Form either directly or on behalf of the Class member or as its Authorized Agent, and, in turn, have been given the authority to submit this Claim Form by each Class member identified in this Claim Form and in any attachments to it, and to receive on behalf of each such Class member any and all amounts that may be allocated from the TPP Settlement Pool to such Class member; (2) each entity on whose behalf I have submitted a claim is a TPP Class member; (3) the information contained in this Claim Form and any attachments hereto is true and accurate, based on records maintained by or otherwise available to me; (4) I, the Authorized Agent (if any), and the Class member on whose behalf this Claim Form is submitted, hereby submit to the jurisdiction of the United States District Court for the District of Puerto Rico (the "Court") for all purposes associated with this Claim Form and the settlement, including resolution of disputes relating to this Claim Form; and (5) in the event that amounts from the TPP Settlement Pool are distributed to the Authorized Agent of a Class member, and the Class member later claims that the Authorized Agent did not have the authority to claim and receive such amounts on its behalf, the Authorized Agent, I and/or my employer will hold the Class, Counsel for the Class, Defendants, Counsel for Defendants, and the Claims Administrator harmless with respect to any claims made by said Class member.

Signature

Position

Print Name

Month/Day/Year

The following additional information is to be provided by the Individual that signs and certifies this Claim Form: I am filing this Claim Form as the authorized employee of the following Class member or Authorized Agent for Class member:

Name of Individual's Employer

Business Address

City

State

Zip Code

Area Code – Telephone Number

Area Code – Fax Number

Email Address

Mail the completed Claim Form to:

Simonet Paxil CR® Claims Administrator
c/o Rust Consulting, Inc.
P.O. Box 24661
West Palm Beach, FL 33416

postmarked by August 10, 2009.

