RITE AID OPIOID PERSONAL INJURY TRUST DATA SHEET

This Rite Aid Opioid Personal Injury Trust Data Sheet (**"PI Trust Data Sheet**") must be completed by each PI Claimant seeking an Award from the Rite Aid Opioid Personal Injury Trust (the "**PI Trust**") on a PI Opioid Claim.

FAILURE TO SUBMIT THIS PI TRUST DATA SHEET AS PROVIDED IN THE RITE AID OPIOID PERONAL INJURY TRUST DISTRIBUTION PROCEDURES ("PI TDP") MAY CAUSE THE PI OPIOID CLAIM TO BE DEEMED NON-COMPENSABLE UNDER THE PI TDP.

This data sheet is to be completed for only ONE Personal Injury (PI) Opioid Claimant. If you represent more than one PI Opioid Claimant, then complete a data sheet for each one. One PI Trust Data Sheet submitted for a PI Opioid Claim shall be deemed to be a PI Trust Data Sheet in respect of that PI Opioid Claim.

Follow the instructions of each section carefully to ensure that your PI Trust Data Sheet is submitted correctly. If any section does not pertain to your claim, leave it blank. Except as otherwise indicated, all words shall be given their ordinary, dictionary meaning. Submitting this PI Trust Data Sheet does not guarantee that you will receive payment from the PI Trust. Whether you will receive payment depends on whether you provide the required submissions, as set forth in the PI TDP and whether your claim meets the eligibility requirements set forth in the PI TDP.

PI Opioid Claim Submission

You must submit this PI Trust Data Sheet along with your HIPAA Form and Evidence for Establishing Use of a Qualifying Opioid as outlined in the PI TDP.

Also, if the individual the claim is being filed on behalf of is deceased, then a Death Certificate with Estate Documents or Heirship Declaration should be provided as well.

Claims can be submitted online at riteaidpitrust.com or you may submit the completed PI Opioid Claim by emailing it to riteaidpitrust@riteaidpitrust.com, mailing it to Rite Aid PI Trust, P.O. Box 361930, Hoover, Alabama, 35236-1930 or faxing it to 205-716-2364.

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PERSONAL INFORMATION OF PI CLAIMANT

At the top of page 2, please provide your Proof of Claim Number(s) assigned by Kroll for this specific Claim.

Please fill out only one of the following sections (Section A or B).

- **If you hold a PI Opioid Claim arising from your own purchase of a qualified opioid prescription filled by Rite Aid (or if such holder is alive and you are completing this Data Sheet as his/her representative), fill out Section A.**
- **If you hold a PI Opioid Claim due a deceased person's purchase of a qualified opioid prescription filled by Rite Aid (or you are completing this Data Sheet on behalf of such a holder as his/her representative), fill out Section B.**

Kroll Proof of Claim Number(s): _____

Section A: If you hold a PI Opioid Claim arising from your own purchase of a qualified opioid prescription filled by Rite Aid (or if such holder is alive and you are completing this Data Sheet as his/her representative), then please fill out the information below:

Claimant's Name: _____

Claimant's Date of Birth: _____

Claimant's Address: _____

Claimant's Social Security Number or
Taxpayer ID or Social Insurance Number (Canada): _____

Representative Name (if applicable): _____

Legal Authority for Representative (if applicable): _____
(e.g., POA, Legal Guardian, Conservator)

Section B: If you are filing a PI Opioid Claim for a deceased person with a claim due to the deceased person's purchase of a qualified opioid prescription filled by Rite Aid, or you are completing this Data Sheet as the representative of an individual with a claim for a deceased person's purchase of a qualified opioid prescription filled by Rite Aid, please fill out the information below:

Deceased Person With Prescription Filled by Rite Aid: _____

Date of Birth of Deceased Person: _____

Date of Death: _____

Social Security Number (or Taxpayer ID or
Social Insurance Number (Canada) of the Deceased Person: _____

Name of Claimant Filing Claim on behalf of
the Deceased Person: _____

Claimant's Address: _____

Claimant's Relationship to the Deceased Person: _____
(i.e., parent, sibling, child, spouse, etc.)

Representative Name (if applicable): _____

Legal Authority for Representative (if applicable): _____
(e.g., POA, Legal Guardian, Conservator)

If a Court has appointed you as Executor, Administrator or Personal Representative of the Deceased Person's Estate, then submit the Court Order so appointing you along with your PI Trust Data Sheet. If a Court has not appointed you as Executor, Administrator, or Personal Representative of the Deceased Person's Estate, then also complete a d submit the Heirship Declaration.

HIPAA RELEASE FORM FOR
RITE AID OPIOID PI TRUST DISTRIBUTION PROCEDURES

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claimant Name:_____ **Date:**_____

Date of Birth:_____ **Soc. Sec. No.**_____

1. The following individuals or organizations are authorized to disclose my health records to the parties specified below in section #4:

_____
_____
_____
_____
_____

(Note: Please list the names of your medical care providers and your health insurance providers that may have records relevant to the resolution of your PI Claim. If you are unsure of the exact legal name of your medical providers and health insurance providers, you can leave this blank, and we will complete it for you with the understanding that you authorize all relevant parties):

2. The type and amount of information to be used or discloses is as follows:

The entire record, including but not limited to: any and all medical records, mental health records, psychological records, psychiatric records, problem lists, medication lists, lists of allergies, immunization records, history and physicals, discharge summaries, laboratory results, x-ray and imaging reports, medical images of any kind, video tapes, photographs, consultation reports, correspondence, itemized invoices and billing information, and information pertaining to Medicaid or Medicare eligibility and all payments made by those agencies, for the following dates:
Dates of Services - From:_____ To: _____

(Note: List the date range for which the medical providers and insurance companies above may have records relevant to the resolution of your PI Claim. If you are unsure of the exact dates, then leave this blank, and we will complete this section for you with the understanding that you authorize all relevant date ranges).

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, as well as treatment for alcohol and drug abuse.

4. The health information may be disclosed to and used by the following individual and/or organization:

    a. Rite Aid Opioid Personal Injury Trust
    b. Edgar C. Gentle, III., of Gentle, Turner & Benson, LLC, as the Trustee and Claims Administrator of the Rite Aid Opioid Personal Injury Trust

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 10 years after the date that I sign it.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and forego a recovery under the Rite Aid Opioid Personal Injury Trust Distribution Procedures. I understand that no organization may condition treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1634.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules or HIPAA. If I have questions about disclosure of my health information, I can contact the parties listed above in section #4.

_____ _____

Patient or Legal Representative Date

_____

Relationship to Patient (If signed by Legal Representative)