

## SUPPLEMENTAL NOTICE

**TO: All Individuals Who Submitted A Health Statement Without The Required Physician Verification In Response To The Notice Of The Settlement Of The Class Action Entitled O'Connor, et al. v. Blue Cross of California**

YOU ARE HEREBY NOTIFIED that the health statement which you submitted in response to the settlement of the class action entitled O'Connor, et al. v. Blue Cross of California is deficient. Pursuant to the order of the Superior Court of the State of California for the County of Los Angeles you were required to submit a health statement verified by a physician. The health statement you submitted, however, did not contain the required signature from a physician.

In order for your claim to be processed, you must submit one of the following by July 18, 1997:

1. The enclosed health statement completely filled out and signed under oath by both you and a physician; or
2. The enclosed statement of inability to comply with the physician verification requirement on which you will provide a written explanation of the reason or reasons why you are unable to provide the required signature from a physician. This statement of inability to comply must be signed by you under penalty of perjury and notarized before a person authorized under California law to do so.

**Failure to complete and submit one of the enclosed forms by the July 18, 1997, deadline will result in an automatic denial of your claim.** Accordingly, please submit by no later than July 18, 1997, either the enclosed health statement completed and signed under oath by both you and a physician or the enclosed statement of inability to comply completed and signed under oath by you before a notary public.

Address your submission, postmarked no later than July 18, 1997, to:

CaliforniaCare Health Insurance Class Action  
2801 Ocean Park Blvd., #11  
Santa Monica, CA 90405

Dated: June 18, 1997

Honorable Bruce Mitchell  
Commissioner of the  
Los Angeles Superior Court



## **HEALTH STATEMENT**

Please check all that apply. Have you, your spouse, or any of your dependents consulted for, been diagnosed, had treatment rendered, been advised to have treatment, or been hospitalized for any of the following conditions from the time you enrolled in Blue Cross' CaliforniaCare HMO under contract no. 1913 to June 1993?

<b>Yes</b>	<b>No</b>	
_____	_____	Cardiovascular surgery, heart attack, coronary artery disease, stroke, angina, or TIA's
_____	_____	Chronic respiratory or lung disorders (i.e., COPD, emphysema)
_____	_____	Ulcerative colitis or Crohn's Disease
_____	_____	Chronic gastrointestinal, chronic metabolic, or chronic endocrine disease (i.e., cirrhosis, chronic hepatitis, Gaucher's Disease, cystic fibrosis, Cushing's Disease, Addison's Disease, or pituitary)
_____	_____	Insulin-dependent diabetes mellitus
_____	_____	Immune deficiency disorder (i.e., AIDS or AIDS related condition)
_____	_____	Cancer (Including Hodgkins' Disease, leukemia)
_____	_____	Brain, central nervous system, or neuromuscular disorders (i.e., Parkinson's, Alzheimers, muscular dystrophy, or paralysis)
_____	_____	Kidney disorders or dialysis
_____	_____	Joint replacement due to degenerative conditions
_____	_____	Any organ transplant (except cornea)
_____	_____	Blood or blood clotting disorder (i.e., hemophilia)
_____	_____	Connective tissues, auto-immune disorders (i.e., SLE, scleroderma, rheumatoid arthritis)
_____	_____	Substance abuse

**To the Subscriber:** *(Please sign below to indicate that all information provided is true and correct.)*

I declare under penalty of perjury under the laws of the State of California that the information set forth in the Questionnaire and the Health Statement is true and correct, and that this verification was executed by me this \_\_\_\_\_ day of \_\_\_\_\_ 1997, at \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Signature of Subscriber

**To the Physician:** *(Please sign below to indicate that the Health Statement is true and correct.)*

I declare under penalty of perjury under the laws of the State of California that the information set forth in the Health Statement is true and correct, and that this verification was executed by me this \_\_\_\_\_ day of \_\_\_\_\_ 1997, at \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_

Physician Name (printed)

Physician Signature

**NOTARIZED STATEMENT OF INABILITY TO COMPLY  
WITH PHYSICIAN VERIFICATION REQUIREMENT**

I, \_\_\_\_\_, hereby declare under oath that I am unable to comply with the physician verification requirement for the following reason(s):

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this \_\_\_\_\_ day of \_\_\_\_\_, 1997, at \_\_\_\_\_, California.

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**This Section Is For Use By Certified Public Notary Only:**

State of California            )  
County of \_\_\_\_\_)

On \_\_\_\_\_, 1997, before me, \_\_\_\_\_,  
personally appeared \_\_\_\_\_,

personally known to me -**OR**-  proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal

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SIGNATURE OF NOTARY