CLAIM SUBMISSION FORM

Goidel et al. v. Aetna Life Insurance Company
U.S. District Court, Southern District of New York
Case No. 1:21-cv-07619 (VSB)

CATEGORY C AND D CLASS MEMBERS MUST COMPLETE AND RETURN THIS FORM SO IT IS RECEIVED BY AUGUST 26, 2025 TO BE ELIGIBLE FOR AN APPROXIMATE $10,000 PAYMENT

COMPLETION AND SUBMISSION OF THIS FORM IS NOT GUARANTEE OF ELIGIBILITY. YOU MUST COMPLETE AND SUBMIT THIS FORM TO BE CONSIDERED.

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

ELIGIBILITY

If you sought or could have sought coverage for one or more cycles of artificial insemination (intracervical insemination ("ICI") or intrauterine insemination ("IUI")) (described below in Step 2) received between September 1, 2017, and May 31, 2024, you were in an Eligible LGBTQ+ Relationship as described in the Settlement Notice at the time, you have not requested exclusion from this settlement, and you complete and timely submit this form and the required Attestation Form, you may be entitled to an approximate $10,000 payment, or a proportionally reduced payment if there are more than 200 class members. **Submission of this form is required if you've been identified as a potential Category C or D Class Member.**

GENERAL CLAIM SUBMISSION FORM INFORMATION

Failure to comply with the instructions for completing a claim described on the next page 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. Any documents submitted as supporting evidence will not be returned. Please retain copies of your documents for your own records.

INSTRUCTIONS FOR COMPLETING A CLAIM

BEFORE YOU BEGIN COMPLETING THIS FORM, contact the provider or providers you received artificial insemination from between September 1, 2017, and May 31, 2024, and request the following information that will be required to complete this Claim Submission Form.

I am participating in a class action settlement related to coverage for the provision of infertility services received between September 1, 2017 and May 31, 2024 and have been asked by my health insurer to provide the following information about the artificial insemination services I received from you during that time:

(1) Provider Name
(2) Provider Address
(3) Provider TIN/PIN
(4) National Provider Identifier (NPI)

For each service received during the relevant time period, please fill out the following:

CPT Code (check one):

____ S4035 (Artificial Insemination; Menotropin)

____ 58321 (Artificial Insemination; Intra-Cervical)

____ 58322 (Artificial Insemination; Intra-Uterine)

Date of Service: _____

The amount billed to me for this service is: $ _____

The amount I paid for this service is: $ _____

You will also need the CPT Code(s) associated with the artificial insemination(s) you underwent. Descriptions of the applicable CPT Codes used for artificial insemination procedures covered by this settlement are as follows:

(1) S4035-Artificial Insemination Menotropin
Stimulated intrauterine insemination

(2) 58321-Artificial Insemination; Intra-Cervical
In this procedure, the provider inserts prepared live sperm into the cervical canal.

(3) 58322-Artificial Insemination; Intra-Uterine
In this procedure, the provider inserts prepared live sperm into the uterus through the cervical canal.

Cycles of in-vitro insemination ("IVF") will not qualify you for Class Membership and should not be submitted.

In order to be considered for a payment, this Claim Form and the Attestation Form must be fully completed, signed under penalty of perjury, and received by the Settlement Administrator on or before August 26, 2025 using one of the following methods:

ONLINE: www.InfertilityInsuranceSettlement.com
MAIL: Infertility Insurance Settlement
c/o Atticus Administration
PO Box 64053
St. Paul MN 55164
EMAIL: InfertilityInsuranceSettlement@atticusadmin.com
FAX: 1-888-326-6411

STEP 1: CLASS MEMBER INFORMATION

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.

COMPLETE THIS PORTION OF STEP 1 ONLY IF YOU ARE ACTING ON BEHALF OF A CLASS MEMBER

Representative First Name | **Representative Last Name** | **M.I.**

Representative Address

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

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

STEP 2: ARTIFICIAL INSEMINATION HISTORY

Please provide the information in the following chart for each cycle of artificial insemination that you underwent between September 1, 2017, and May 31, 2024 that was not previously submitted to Aetna. Supporting evidence for each procedure you include is required and must be submitted with this form to verify your claim. Add additional procedures on a separate piece of paper if necessary.

FIRST CYCLE BETWEEN SEPTEMBER 1, 2017 AND MAY 31, 2024:

Date of Service (mm/yy/dddd): _____

CPT Code- Check the box(s) that apply (see page 2):

S4035 ☐
58321 ☐
58322 ☐

Provider TIN/PIN: _____ Provider NPI: _____

Provider Name: _____

Provider Address: _____

_____

_____

Provider Phone: _____ Amount Paid _____

SECOND CYCLE BETWEEN SEPTEMBER 1, 2017 AND MAY 31, 2024:

Date of Service (mm/yy/dddd): _____

CPT Code- Check the box(s) that apply (see page 2):

S4035 ☐
58321 ☐
58322 ☐

Provider TIN/PIN: _____ Provider NPI: _____

Provider Name: _____

Provider Address: _____

_____

_____

Provider Phone: _____ Amount Paid _____

THIRD CYCLE BETWEEN SEPTEMBER 1, 2017, AND MAY 31, 2024:

Date of Service (mm/yy/dddd): _____

CPT Code- Check the box(s) that apply (see page 2):

S4035 ☐
58321 ☐
58322 ☐

Provider TIN/PIN: _____ Provider NPI: _____

Provider Name: _____

Provider Address: _____

_____

_____

Provider Phone: _____ Amount Paid _____

**Please visit www.InfertilityInsuranceSettlement.com for an Appendix to the Claim Form for additional cycle history.*

STEP 4: DOCUMENTATION

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: CERTIFICATION AND SIGNATURE

I certify under penalty of perjury that the information included in this Claim Submission Form and the accompanying supporting evidence are true and correct to the best of my knowledge.

_____ _____

Signature Date (mm/dd/yyyy)

Information on where and how to submit your Claim Submission Form can be found on page 2.