Your claim must be postmarked by: **04/28/2025**	**STATE OF WASHINGTON, COUNTY OF KING** *John Doe v. Virginia Mason Medical Center, et al.,* Case No. 19-2-26674-1 SEA	**Virginia Mason Medical Center & Virginia Mason Health System**

Claim Form

You should fill out and submit this claim form online or by mail if you are a Settlement Class Member and you would like to receive a payment from the settlement.

You are a Settlement Class Member if you are a Washington State resident, you are or were a patient of Virginia Mason Medical Center or Virginia Mason Health System between October 10, 2015 and May 18, 2023, and you logged into the MyVirginiaMason patient portal or used Virginia Mason's public website, www.VirginiaMason.org, to view or search for medical-related information.

You may receive a payment if you fill out this claim form completely, if the settlement is approved, and if you are found to be eligible for a payment.

The settlement notice describes your legal rights and options. Please visit the official settlement administration website, www.virginiamasonprivacyclassaction.com, or call 1-844-609-1124 for more information.

If you wish to submit a claim for a settlement payment, you need to provide all of the applicable information requested below, including the **Settlement Claim ID** specified on the front page of the notice document you received. If you do not clearly provide the applicable requested information, and indicate that you qualify and would like to receive benefits from the settlement, your claim form will be deemed invalid and your claim will be denied.

Please print clearly in blue or black ink. This claim form must be submitted online or postmarked by **April 28, 2025**.

I. CLASS MEMBER NAME AND CONTACT INFORMATION

Provide your name and contact information below. You must notify the Settlement Administrator if your contact information changes after you submit this form.

First Name | **Last Name**

Street Address

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

Phone Number | **Email Address**

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II. BENEFIT SELECTION

Please complete one or both sections below, as applicable.

If you logged into the MyVirginiaMason patient portal

If you logged into the MyVirginiaMason patient portal, you may request compensation for claims associated with alleged web tracking of logins to the patient portal and activity within the patient portal. You may be entitled to a payment of $90, subject to a possible adjustment depending on the total number of claims for benefits.

_______ I attest that I am or I was a patient of Virginia Mason Medical Center or Virginia Mason Health System or one of their affiliates between October 10, 2015 and May 18, 2023, and I logged into and used the MyVirginiaMason patient portal.

Settlement Claim ID: _______________

If you used Virginia Mason's public website, www.virginiamason.org

If you used Virginia Mason's public website, www.virginiamason.org, you may request compensation for claims associated with alleged web tracking of viewing or searching for medical-related information on the website. You may be entitled to a payment of $45, subject to a possible adjustment depending on the total number of claims for benefits.

_______ I attest that I am or I was a patient Virginia Mason Medical Center or Virginia Mason Health System or one of their affiliates between October 10, 2015 and May 18, 2023, and I used www.VirginiaMason.org to view or search for medical symptoms, conditions, or treatment options related to my own healthcare.

Settlement Claim ID: _______________

III. PAYMENT OPTIONS

Please select **one** of the following four payment options:

PayPal - Enter your PayPal email address: ____

Venmo - Enter the mobile number associated with your account: __ __ __-__ __ __-__ __ __ __

Zelle - Enter the mobile number or email address associated with your account:

Mobile Number: __ __ __-__ __ __-__ __ __ __ or Email Address: ______________________________

Physical Check - Payment will be mailed to the address provided above.

Your claim must be postmarked by: **04/28/2025**

STATE OF WASHINGTON, COUNTY OF KING

John Doe v. Virginia Mason Medical Center, et al.,
Case No. 19-2-26674-1 SEA

Claim Form

Virginia Mason Medical Center & Virginia Mason Health System

IV. SIGN AND DATE YOUR CLAIM FORM

I declare that the information I supplied in this claim form is true and correct to the best of my recollection, and that I executed this form on the date set forth below.

____
Your signature

Date: ______________________________
MM DD YYYY

____
Your name

MAIL YOUR CLAIM FORM OR SUBMIT YOUR CLAIM FORM ONLINE.

This claim form must be:

Postmarked by April 28, 2025 and mailed to: Virginia Mason Settlement Administrator, c/o EisnerAmper;

OR

Submitted through the Settlement Website by midnight on April 28, 2025 at: 11:59 P.M. CST.