DevaCurl Products Settlement Administrator
P.O. Box 43501
Providence, RI 02940-3501

[redacted]

DVC

In re: Deva Concepts Products Liability Litigation

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Master File No. 1:20-cv-1234

Must Be Postmarked
No Later Than
November 21, 2021

DEVACURL HAIRCARE PRODUCTS SETTLEMENT CLAIM FORM

INSTRUCTIONS

1. Please complete all steps of this Claim Form. You must submit all of the required information and documentation in order to have a valid claim.
2. To complete the Claim Form, you must sign and date the Declaration at the bottom of this form.
3. If you claim to have seen a doctor or other medical provider related to your hair loss and/or scalp irritation, **you must obtain your records from your provider and submit your medical records in support of your claim. The Settlement Administrator will not retrieve your medical records for you.**
4. Return your signed and completed Claim Form and all of your documentation postmarked by **November 21, 2021**. Your Claim Form can be submitted by mail, email or online:

   By mail: DevaCurl Products Settlement Administrator
   P.O. Box 43501
   Providence, RI 02940-3501

   By email: **info@curlyhairsettlement.com**

   Online: **www.CurlyHairSettlement.com**

5. QUESTIONS? Visit the settlement website at **www.CurlyHairSettlement.com** or call 1-855-786-1011.

STEP ONE: CLASS MEMBER IDENTIFICATION

First Name | M.I. | Last Name

Primary Address

Primary Address Continued

City | State | ZIP Code

Email Address

Area Code — Telephone Number (Home) — Area Code — Telephone Number (Work)

FOR CLAIMS PROCESSING ONLY	OB	CB	○ DOC ○ LC ○ REV	○ RED ○ A ○ B

STEP TWO: ATTORNEY NAME AND CONTACT INFORMATION (IF REPRESENTED)

I am represented by an attorney. ○ Yes ○ No

If yes, please list your attorney's name and contact information below. If no, continue to Step Three.

Name of Attorney

Mailing Address of Attorney

City State ZIP Code

Phone Number of Attorney

___ — ___ — ____

Email Address of Attorney

STEP THREE: CLASS MEMBERSHIP & BACKGROUND

Please provide information for all of the statements below.

1. I purchased DevaCurl Products approximately ___ times between February 8, 2008 and August 29, 2021.
2. I purchased DevaCurl Products through the following outlet(s) (Fill all that apply):
   ○ www.devacurl.com ○ Ulta ○ CosmoProf ○ Other professional beauty outlet
   ○ Sephora ○ Other specialty beauty retailers ○ Amazon ○ DevaChan Salon ○ Other salon
3. I used DevaCurl Products between the approximate dates:
   MM / DD / YYYY to MM / DD / YYYY

TIER 1 CLAIM FORM (Class Members can submit only one claim, either a Tier 1 Claim or a Tier 2 Claim)

○ I certify that I have purchased, used, or had used on me DevaCurl Products and would like to make a claim of up to $20 from this Settlement. Please continue to Step Eleven: Declaration on Page 12 of this form.

TIER 2 CLAIM FORM

STEP FOUR: DAMAGE TO HAIR & SCALP

Please complete all of the questions/statements below. As explained below, you must supply a personal statement fully describing your injuries.

1. When was the approximate date you began to notice injury to your hair or scalp?
   MM / DD / YYYY

2. I suffered from the following injuries (Fill all that apply):

○ Loss of hair ○ Change in hair texture ○ Hair breakage ○ Loss of hair color/color change

○ Bald spots ○ Visible thinning ○ Damage to scalp ○ Change of curl pattern

○ Other

3. If you suffered from hair loss, what was the extent of your hair loss? Please provide estimated percentage of hair loss:

○ Less than 25% ○ 25% ○ 50% ○ 75% ○ 100%

4. Has your hair loss and/or irritation stopped? ○ Yes ○ No

5. If yes, how long did it take for the hair loss and/or irritation to stop?

○ 3 months or less ○ 3 to 6 months ○ 6 months to 1 year ○ More than 1 year ○ More than 2 years

6. If no, what estimated percentage of your hair has *not* grown back?

○ Less than 25% ○ 25% ○ 50% ○ 75% ○ 100%

7. Did you contact the outlet from which you purchased DevaCurl Products or anyone else with a complaint about the damage to your hair or scalp? ○ Yes ○ No

   a. If you made a complaint, what is the approximate date of your complaint?

   M M / D D / Y Y Y Y

   b. If you made a complaint, with whom did you make your complaint? (Fill all that apply):

   ○ DevaCurl Corporate ○ DevaChan Salon ○ Other salon ○ Ulta ○ Sephora

   ○ Amazon ○ Government entity ○ Other retailer

   ○ Other. Please add additional details below.

   c. I have attached a copy of my complaint or communications referenced in 7 above. ○ Yes ○ No

   What were your estimated out-of-pocket costs relating to the damage of your hair and/or scalp? $.

   What type of expenses did you incur?

   ○ Purchased wigs ○ Purchased therapeutic hair or scalp products ○ Medical bills ○ Purchased headbands

   ○ Purchased extensions ○ Salon treatments ○ Special haircuts

8. Do you have documentation and/or any evidence that you can provide along with this Claim Form? ○ Yes ○ No

9. If yes, attach copies of the documentation to this Claim Form.

STEP FIVE: EMOTIONAL INJURIES

If you are making a claim for emotional injuries, please complete all of the questions/statements below and attach any additional documentation or statements you may have. You must supply a written or video statement fully describing any emotional injuries that resulted from the damage to your hair and/or scalp.

1. As a result of the damage to my hair and/or scalp, I have one or more of the following conditions (Fill all that apply):

   ○ Anxiety ○ Depression ○ Damage to self-esteem ○ Impaired daily activity

   ○ Impaired ability to do my job ○ Damage to relationships ○ Affected special event

   ○ Other. If other, please explain briefly and in detail in your statement:

2. How long did your emotional injuries last?

   M M / D D / Y Y Y Y to M M / D D / Y Y Y Y

3. Did you seek professional help, like counseling, for your emotional damages? ○ Yes ○ No

4. If yes, what type of treatment did you seek? (Fill all that apply):

   ○ Psychiatrist ○ Psychologist ○ Counselor, Clinician, or Therapist ○ Social Worker

   ○ Mental Health Nurse Practitioner ○ Primary Care Physician

   Name of Provider

   Practice

   Address

   City State ZIP Code

   Phone Number

   — —

5. How many times have you gone to treatment? times

6. What time period did you go to treatment?

   M M / D D / Y Y Y Y to M M / D D / Y Y Y Y

7. Are you still seeking treatment? ○ Yes ○ No

8. Do you have documentation and/or any evidence that you can provide along with this Claim Form? ○ Yes ○ No

9. If yes, attach copies of the documentation to this Claim Form.

STEP SIX: MEDICAL CONDITIONS

1. Have you ever suffered from any hair loss or scalp irritation **prior** to using DevaCurl Products? ○ Yes ○ No

2. If yes, when did this occur?

   M M / D D / Y Y Y Y to M M / D D / Y Y Y Y

3. Have you experienced any of the following in the three years before, during, or after your use of DevaCurl Products? (Fill all that apply):

○ Pregnancy ○ Death of a Close Friend/Family Member ○ Job Change

○ Financial Troubles (i.e., declared bankruptcy; lost job) ○ Divorce

○ Other Stressors

4. Have you ever suffered from any of the following in the three years prior to or during your use of DevaCurl Products? (Fill all that apply):

○ Hormone replacement therapy ○ Autoimmune disease ○ Alopecia ○ Thyroid problems

○ Psoriasis or other skin condition ○ Depression ○ Perimenopause or menopause ○ Cancer

○ Other

5. Have you had any of the following treatments prior to or during your use of DevaCurl Products? (Fill all that apply):

○ Chemotherapy ○ Radiation ○ Fertility

○ Other

6. If you had hair loss or scalp irritation prior to using DevaCurl Products, did your hair loss or scalp irritation worsen, improve, or stay the same after you started using DevaCurl Products?

○ Worsen ○ Improve ○ Stay the same

STEP SEVEN: MEDICAL TREATMENTS

If you claim to have seen a doctor or other medical provider related to your hair loss and/or scalp irritation, you are required to reimburse, in whole or in part, any public or private insurance company that paid for any portion of your relevant treatment. We will contract with a lien subrogation firm to negotiate these payments. These negotiations take time. THIS WILL LIKELY DELAY YOUR PAYMENT FOR UP TO ONE YEAR, POTENTIALLY LONGER. To avoid unnecessary delay, DO NOT claim to have seen a medical provider if you did not see a medical provider directly in connection with your use of DevaCurl Products.

Did you see a doctor or other medical provider related to your hair loss and/or scalp irritation? ○ Yes ○ No

If yes, complete this section. If no, continue to the next step.

Under the terms of the Settlement, you may be reimbursed for any out-of-pocket expenses you incurred as a result of the hair loss or scalp irritation. However, **PROOF OF PAYMENT IS REQUIRED** for reimbursement, such as receipts, cancelled checks, bank statements, account statements, etc. Medical payments covered by insurance will not be reimbursed. Co-pay or out-of-pocket medical payments related to hair loss or scalp irritation qualify for reimbursement. Payments made by your insurance company are not recoverable.

In the section below, list your out-of-pocket expenses for medical treatments, approximate date of payment and to whom payment was made. **Attach the corresponding documentation to your Claim Form.** Please attach an additional sheet if you have additional expenses. If you need additional space, please attach additional sheets as necessary. If some of your expenses were paid by insurance or otherwise reimbursed, please indicate below.

Date

MM / DD / YYYY

Amount Paid

$.

Proof attached?

○ Yes ○ No

Name of Provider

Description of Services

Address

City

State

ZIP Code

Phone Number

— —

Type of Provider

○ Primary care physician/family doctor ○ Dermatologist ○ Specialist ○ Psychiatrist ○ Therapist

○ Other

Name of Insurance Provider

Member ID

Plan Number

Group Number

Diagnosis

○ Telogen effluvium (temporary hair loss) ○ Thyroid disease ○ Alopecia areata ○ Hereditary hair loss

○ Scarring alopecia ○ Cancer treatment ○ Hormonal imbalance syndrome (PCOS) ○ Scalp infection

○ Medication side effects ○ Scalp psoriasis ○ Deficiency of iron, biotin, protein, or zinc ○ Major psychological stress

○ Abrupt hormonal changes (including those associated with childbirth and menopause)

Date

M M / D D / Y Y Y Y

Amount Paid

$.

Proof attached?

○ Yes ○ No

Name of Provider

Description of Services

Address

City

State

ZIP Code

Phone Number

— —

Type of Provider

○ Primary care physician/family doctor ○ Dermatologist ○ Specialist ○ Psychiatrist ○ Therapist

○ Other

Name of Insurance Provider

Member ID

Plan Number

Group Number

Diagnosis

○ Telogen effluvium (temporary hair loss) ○ Thyroid disease ○ Alopecia areata ○ Hereditary hair loss

○ Scarring alopecia ○ Cancer treatment ○ Hormonal imbalance syndrome (PCOS) ○ Scalp infection

○ Medication side effects ○ Scalp psoriasis ○ Deficiency of iron, biotin, protein, or zinc ○ Major psychological stress

○ Abrupt hormonal changes (including those associated with childbirth and menopause)

Date

MM / DD / YYYY

Amount Paid

$.

Proof attached?

○ Yes ○ No

Name of Provider

Description of Services

Address

City

State

ZIP Code

Phone Number

— —

Type of Provider

○ Primary care physician/family doctor ○ Dermatologist ○ Specialist ○ Psychiatrist ○ Therapist

○ Other

Name of Insurance Provider

Member ID

Plan Number

Group Number

Diagnosis

○ Telogen effluvium (temporary hair loss) ○ Thyroid disease ○ Alopecia areata ○ Hereditary hair loss

○ Scarring alopecia ○ Cancer treatment ○ Hormonal imbalance syndrome (PCOS) ○ Scalp infection

○ Medication side effects ○ Scalp psoriasis ○ Deficiency of iron, biotin, protein, or zinc ○ Major psychological stress

○ Abrupt hormonal changes (including those associated with childbirth and menopause)

Date

MM / DD / YYYY

Amount Paid

$.

Proof attached?

○ Yes ○ No

Name of Provider

Description of Services

Address

City

State

ZIP Code

Phone Number

— —

Type of Provider

○ Primary care physician/family doctor ○ Dermatologist ○ Specialist ○ Psychiatrist ○ Therapist

○ Other

Name of Insurance Provider

Member ID

Plan Number

Group Number

Diagnosis

○ Telogen effluvium (temporary hair loss) ○ Thyroid disease ○ Alopecia areata ○ Hereditary hair loss

○ Scarring alopecia ○ Cancer treatment ○ Hormonal imbalance syndrome (PCOS) ○ Scalp infection

○ Medication side effects ○ Scalp psoriasis ○ Deficiency of iron, biotin, protein, or zinc ○ Major psychological stress

○ Abrupt hormonal changes (including those associated with childbirth and menopause)

Less Amount Paid by Insurance or Otherwise Reimbursed: $.

Total Out-of-Pocket Expenses: $.

If you have seen a doctor or other medical provider related to your hair loss, scalp irritation and/or emotional distress, you will need to provide an authorization for the release of medical records and billing information for your doctor or other medical provider under the Health Insurance Portability and Accountability Act ("HIPAA") and other similar laws. Please complete such Medical Records Authorization for each medical provider.

STEP EIGHT: OTHER TREATMENTS & EXPENSES

Please complete all of the questions/statements below and attach any additional documentation or statements you may have.

As a result of the damage to my hair and/or scalp from the use of DevaCurl Products, I used the following treatments to repair the damage to my hair and/or scalp or address a change in my appearance (Fill all that apply):

○ Salon treatments ○ Special haircuts ○ Wigs ○ Extensions ○ Home treatment/Over-the-counter
○ Other

Under the terms of the Settlement, you may be reimbursed for any out-of-pocket expenses you incurred as a result of the hair loss or scalp irritation. However, **PROOF OF PAYMENT IS REQUIRED** for reimbursement, such as receipts, cancelled checks, bank statements, account statements, etc.

In the section below, list your out-of-pocket expenses, approximate date of payment and to whom payment was made. **Attach the corresponding documentation to your Claim Form.** Please attach an additional sheet if you have additional expenses. If you need additional space, please attach additional sheets as necessary.

Date
MM / DD / YYYY

Amount Paid
$.

Proof attached?
○ Yes ○ No

Name of Provider

Description of Services

Address

City

State

ZIP Code

Phone Number
— —

Type of Provider or Treatment Received

○ Salon treatments ○ Special haircuts ○ Wigs ○ Extensions ○ Home treatment/Over-the-counter ○ Other

○ Primary care physician/family doctor ○ Dermatologist ○ Specialist ○ Psychiatrist ○ Therapist

Date
MM / DD / YYYY

Amount Paid
$.

Proof attached?
○ Yes ○ No

Name of Provider

Description of Services

Address

City

State

ZIP Code

Phone Number
— —

Type of Provider or Treatment Received
○ Salon treatments ○ Special haircuts ○ Wigs ○ Extensions ○ Home treatment/Over-the-counter ○ Other

○ Primary care physician/family doctor ○ Dermatologist ○ Specialist ○ Psychiatrist ○ Therapist

---

Date
MM / DD / YYYY

Amount Paid
$.

Proof attached?
○ Yes ○ No

Name of Provider

Description of Services

Address

City

State

ZIP Code

Phone Number
— —

Type of Provider or Treatment Received
○ Salon treatments ○ Special haircuts ○ Wigs ○ Extensions ○ Home treatment/Over-the-counter ○ Other

○ Primary care physician/family doctor ○ Dermatologist ○ Specialist ○ Psychiatrist ○ Therapist

---

Total Out-of-Pocket Expenses: $.

STEP NINE: PROOF OF INJURIES & WITNESS STATEMENTS

1. **Proof of injuries and witness statements.** Do you have documentation of your proof of injuries and/or witness statements that corroborate your claims? ☐ Yes ☐ No

2. If yes, and even if already included with the Claim Form as requested above, please identify what form of proof you are including:

   a. Photos: Before and after photos of the damage to your hair and/or scalp. Each photo must be dated and labeled as either "before" or "after" photos. ☐ Yes ☐ No

   b. Medical records: Copies of medical records, doctor's notes, test results and/or a statement from your doctor indicating damage to your hair or scalp after using DevaCurl Products. ☐ Yes ☐ No

   c. Statement from your hair stylist(s): Written or video statements from your hair stylist(s) indicating the amount of hair loss suffered and any lasting effects. ☐ Yes ☐ No

   d. Statements from other witnesses: Written or video statements that can testify about the damage to your hair and its effect on you (e.g., spouse, family, friends). Please be sure to include any witnesses' names and their relationship to you. ☐ Yes ☐ No

If you do provide a video statement, it will need to be sent via email to the following: info@curlyhairsettlement.com.

3. **Copies of receipts or other proof of expenses.** As detailed above, in order to be reimbursed for any expenses related to your Claim, **you must submit copies of receipts or other proof of payment along with your Claim Form**.

The extent of scalp irritation and/or hair loss suffered and the duration of the hair loss are two critical components of evaluating your claim. Before and after photographs are often the best resource for demonstrating the amount of hair loss or scalp damage suffered. If you would like to provide additional information in the form of a written statement or video, you may also include any additional information you believe would be helpful in evaluating your claim.

4. **Copies of medical records from medical or mental health providers.** If you claim to have seen a doctor or other medical provider related to your hair loss and/or scalp irritation, **you must obtain your records from your provider and submit your medical records in support of your claim**. **The Settlement Administrator will not retrieve your medical records for you.**

If you claim to have seen a doctor or other medical provider related to your hair loss and/or scalp irritation, you are required to reimburse, in whole or in part, any public or private insurance company that paid for any portion of your relevant treatment. We will contract with a lien subrogation firm to negotiate these payments. These negotiations take time. THIS WILL LIKELY DELAY YOUR PAYMENT FOR UP TO ONE YEAR, POTENTIALLY LONGER. To avoid unnecessary delay, DO NOT claim to have seen a medical provider if you did not see a medical provider directly in connection with your use of DevaCurl Products.

If you claim to have seen a doctor or other medical provider related to your hair loss and/or scalp irritation, you must authorize your health insurance plan and/or their agents to release, upon request, certain protected health information to the Settlement Lien Administrator for the purpose of disclosure and resolution of healthcare and medical liens. This may include authorization to disclose: all enrollment information, medical records and payment information (including itemizations of said payments and supporting information such as ICD-9/10 codes) related to the injury/illness. Please complete the required Authorizations **here**.

STEP TEN: ADDITIONAL INFORMATION

1. Other than the above, are there any additional costs or damages associated with DevaCurl Products that you are claiming? ☐ Yes ☐ No

2. If yes, please attach copies of the documentation (don't send originals) to this Claim Form.

STEP ELEVEN: DECLARATION

I declare, under penalty of perjury, under the laws of the United States, that the information provided in this Claim Form is true and correct.

I certify that I purchased, used, and/or had DevaCurl Products used on me between February 8, 2008 and August 29, 2021 and that all of the information provided in this Claim Form and all of the documents and information filed in support of this Claim Form is true and correct.

Signature: _____ Dated (mm/dd/yyyy): _____

Print Name: _____