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



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.
- If you claim to have seen a doctor or other medical provider related to your hair loss and/or scalp irritation, you <u>must</u> 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: <u>info@curlyhairsettlement.com</u>
Online: <u>www.CurlyHairSettlement.com</u>

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 Z | ZIP Code |
| | | | | |
| Email Address | | | | |
| | | | | |
| Area Code Telephone Number (Home) | | Area Code Telepho | one Number (Wo | ork) |
| | | _ | | |

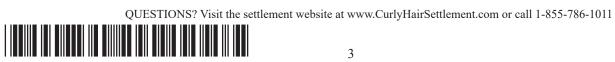


| FOR CLAIMS | | | DOC | RED |
|------------|----|----|-----|-----|
| PROCESSING | ОВ | СВ | LC | A |
| ONLY | | | REV | В |

STEP TWO: ATTORNEY NAME AND CONTACT INFORMATION (IF REPRESENTED) Yes No I am represented by an attorney. 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 ZIP Code City State 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 Other specialty beauty retailers Amazon DevaChan Salon Other salon 3. I used DevaCurl Products between the approximate dates: MM/DD/YYYTIER 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. 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 | | | | | | | | | |
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| | | | | | | | | | | |
| 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 <i>not</i> 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? | | | | | | | | | |
| | a. If you made a complaint, what is the approximate date of your complaint? | | | | | | | | | |
| | | | | | | | | | | |
| | 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. | | | | | | | | | |
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| | 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): Damage to self-esteem Depression Impaired daily activity Anxiety Affected special event Impaired ability to do my job Damage to relationships Other. If other, please explain briefly and in detail in your statement: How long did your emotional injuries last? MM/DD/YYYY MIM DID Y to Did you seek professional help, like counseling, for your emotional damages? Yes No 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 ZIP Code City State Phone Number How many times have you gone to treatment? times What time period did you go to treatment? MM/DD/YYYMIM / DID / to Are you still seeking treatment? 7. Yes No Do you have documentation and/or any evidence that you can provide along with this Claim Form? Yes No 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? to MM / DD / YYY



| 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 | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | |
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| 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 | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | EP SEVEN: MEDICAL TREATMENTS | | | | | | | | | | | | |
| | ou claim to have seen a doctor or other medical provider related to your hair loss and/or scalp irritation, you are required to reimburse, | | | | | | | | | | | | |
| III V | whole or in part, any public or private insurance company that paid for any portion of your relevant treatment. We will contract with | | | | | | | | | | | | |

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.



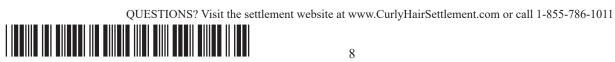
expenses. If you need additional space, please attach additional sheets as necessary. If some of your expenses were paid by insurance or otherwise reimbursed, please indicate below. Date **Amount Paid** Proof attached? MM / DD / YYYY \$ Yes No Name of Provider Description of Services Address ZIP Code City State 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 Hereditary hair loss Alopecia areata Scarring alopecia Cancer treatment Hormonal imbalance syndrome (PCOS) Scalp infection Scalp psoriasis Medication side effects Deficiency of iron, biotin, protein, or zinc Major psychological stress Abrupt hormonal changes (including those associated with childbirth and menopause)

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

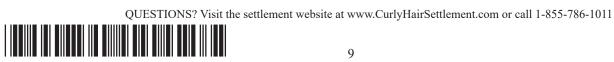


| Date | | Amour | nt Paid | | | | | | | Pı | oof at | tache | d? | |
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| MM/DD/YYYY | \$ | | | | | • | | | | | Yes | | O N | lo |
| Name of Provider | | | | | | | | | | | | | | |
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| Description of Services | | | | | | | | | | | | | | |
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| Address | | | | | | | | | | | | | | |
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| Phone Number | | | | | | | | | | | | | | |
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| Type of Provider | | | | | | | | | | | | | | |
| Primary care physician/family doctor Dermatologist | t | Spec | cialist | | Psyc | hiatri | ist | T | herapi | st | | | | |
| Other | | | | | | | | | | | | | | |
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| Name of Insurance Provider | | | | | | | | | | | | | | |
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| Member ID | | | | | | | | | | | | | | |
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| Group Number | | | | | | | | | | | | | | |
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| Diagnosis | | | | | | | | | | | | | | |
| Telogen effluvium (temporary hair loss) Thyroid dis | sea | se C | Alop | ecia a | reata | a | Н | eredi | tary ha | ir los | S | | | |
| Scarring alopecia Cancer treatment Hormonal | | | syndı | ome | (PC | OS) | | | p infec | | | | | |
| Medication side effects Scalp psoriasis Deficie | enc | y of iro | n, biot | in, pr | oteir | ı, or z | zinc | | Majo | | cholog | gical s | tress | |
| Abrupt hormonal changes (including those associated with | h cl | hildbirt | h and | neno | paus | e) | | | | | | | | |
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| Date | | Amou | unt I | Paid | | | | | | | | Proof | attach | ed? | |
|--|-------|----------|-------|------|-------|-------|-------|------|-------|---------|-------|-------|---------|--------|----|
| MM/DD/YYYY | \$ | | | | | | • | | | | | Yes | ; | | No |
| Name of Provider | | | | | | | | | | | | | | | |
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| Description of Services | | | | | | | | | | | | | | | |
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| Address | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| City | | | | | | | | | State | ; | 2 | ZIP C | ode | | |
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| Phone Number | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Type of Provider | | | | | | | | | | | | | | | |
| Primary care physician/family doctor Dermatologi | st | Spe | ecia | list | | Psyc | hiatr | ist | ОТ | herap | ist | | | | |
| Other | | _ | | | | | | | | | | | | | |
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| Name of Insurance Provider | | | | | | | | | | | | | | | |
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| Diagnosis | | | | | | | | | | | | | | | |
| Telogen effluvium (temporary hair loss) Thyroid d | lisea | ase | A | lope | cia a | reata | 1 | Н | eredi | tary h | air 1 | oss | | | |
| Scarring alopecia Cancer treatment Hormona | | | | • | | | | | | lp infe | | | | | |
| | | y of ire | | | | • | ĺ | zinc | | _ | | | logical | stress | S |
| Abrupt hormonal changes (including those associated wi | | - | | | _ | | | | | J | | | | | |
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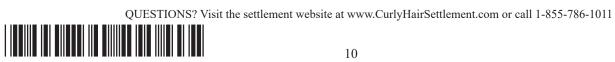


| Date | | Amo | ount | Paid | | | | | | | | Pro | of at | tache | d? | |
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| M M / D D / Y Y Y Y | \$ | | | | | | • | | | | | _ <i>Y</i> | es | | | No |
| Name of Provider | | | | | | | | | | | | | | | | |
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| Description of Services | | | | | | | | | | | | | | | | |
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| Address | | | | | | | | | | | | | | | | |
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| Type of Provider | | | | | | | | | | | | | | | | |
| Primary care physician/family doctor Dermatologist | t | St | pecia | ılist | O] | Psyc | hiatri | st | Т | herap | oist | | | | | |
| Other | | • | | | | Ť | | | | • | | | | | | |
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| Name of Insurance Provider | | | | | | | | | | | | | | | | |
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| Member ID | | | | | | | | | | | | | | | | |
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| Group Number | | | | | | | | | | | | | | | | |
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| Diagnosis | | | | | | | | | | | | | | | | |
| Telogen effluvium (temporary hair loss) Thyroid dis | sea | se | | loped | cia a | reata | 1 | Не | eredit | tary h | nair | loss | | | | |
| Scarring alopecia Cancer treatment Hormonal | | | | • | | | | | | p info | | | | | | |
| Medication side effects | | | | • | | ` | | | | - | | | olog | ical s | tress | |
| Abrupt hormonal changes (including those associated with | | | | | - | | | | | 3 | 1 | | ر | , | | |
| | | | | | | | | | | | | | | | | |
| Less Amount Paid by Insurance or Otherwise Reimbursed: | \$ | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| Total Out-of-Pocket Expenses: | | | 1 . | 1 | | | • | | 1/ | | | 1 1 | | | • • • | |
| If you have seen a doctor or other medical provider related to provide an authorization for the release of medical records | | | | | | | | | | | | | | | | |
| the Health Insurance Portability and Accountability Act ("H Authorization for each medical provider. | | | | | | | | | | | | | | | | |

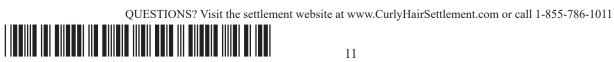


STEP EIGHT: OTHER TREATMENTS & EXPENSES

| 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 | | | | | | | | | | | | | | | | | | | | | | | | |
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| Under the territation. Ho account states | wever, P | ROC | | | | | | | | | | | | | | | | | | | | | | | |
| In the section corresponding additional spa | ıg docu | ment | ation | to y | your | Clai | im F | 'orm | . Ple | ase a | | | | | | | | | | | | | | | |
| Date | | | | | | | | | | | Amo | ount | Paid | | | | | | | | Prod | of att | ache | d? | |
| M M / | DD | / | Υ | Y | Y | Y | | | | \$ | | | | | | • | | | | | Y | es | | | No |
| Name of Prov | vider | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | |
| Description of | f Service | es | | | | | | | | | | | | | | | | | | | | | | | |
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| Address | | | | | | | | | | | | | | | | | | | | | | | | | |
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| City | | | | | | | | | | | | | | | | | | State | • | | ZIP | Code | | | |
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| Phone Numb | er | | | | | | | | | | | | | | | | | | | | | | | | |
| | _ | | | _ | | | | | | | | | | | | | | | | | | | | | |
| Type of Provi | ider or T | reatm | ent R | lecei | ived | | | | | | | | | | | | | | | | | | | | |
| Salon trea | | | Specia | | | ts | W | igs | O I | Exte | nsion | s | Н | me t | reati | ment | /Ov | er-the | e-cou | nter | | Oth | er | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | |
| Primary ca | are physi | cian/ | famil | y do | ctor | | Dei | rmato | ologi | st | \circ S ₁ | pecia | alist | • | Psyc | hiatr | ist | 0 7 | hera | pist | | | | | |



| Date | Amount Paid | Proof attached? |
|---|--------------------------------------|------------------|
| MM/DD/YYYY | \$ | Yes No |
| Name of Provider | | |
| | | |
| Description of Services | | |
| | | |
| Address | | |
| | | |
| City | State | ZIP Code |
| | | |
| Phone Number | | |
| | | |
| Type of Provider or Treatment Received | | |
| | tensions Home treatment/Over-the-cou | nter Other |
| | | |
| Primary care physician/family doctor Dermatologist | Specialist Psychiatrist Thera | pist |
| Data | Amount Paid | Proof attached? |
| Date / D D / V V V | | |
| | | Yes No. |
| | \$. | Yes No |
| Name of Provider | \$ | Yes No |
| Name of Provider | | Yes No |
| | | Yes No |
| Name of Provider Description of Services | | Yes No |
| Name of Provider | | Yes No |
| Name of Provider Description of Services Address | | |
| Name of Provider Description of Services | State | Yes No ZIP Code |
| Name of Provider Description of Services Address City | | |
| Name of Provider Description of Services Address | | |
| Name of Provider Description of Services Address City Phone Number — — — | | |
| Name of Provider Description of Services Address City Phone Number — — — — Type of Provider or Treatment Received | State | ZIP Code |
| Name of Provider Description of Services Address City Phone Number — — — — Type of Provider or Treatment Received | | ZIP Code |
| Name of Provider Description of Services Address City Phone Number — — — — Type of Provider or Treatment Received | State | ZIP Code |



STEP NINE: PROOF OF INJURIES & WITNESS STATEMENTS

| K |) 1 12 1 | . 11111 | E. I ROOF OF INJURIES & WITNESS STATEMENTS | | | |
|---|----------------------------|-----------------------------|--|--------------------------|---|---------------------------------|
| | | | of injuries and witness statements. Do you have documentation of your finjuries and/or witness statements that corroborate your claims? | | Yes | No |
| | 2. If | f yes, a | and even if already included with the Claim Form as requested above, please identify what form | of pro | oof you are | including: |
| | a | | otos: Before and after photos of the damage to your hair and/or scalp. ch photo must be dated and labeled as either "before" or "after" photos. | | Yes | No |
| | b | | edical records: Copies of medical records, doctor's notes, test results and/or a statement m your doctor indicating damage to your hair or scalp after using DevaCurl Products. | | Yes | No |
| | c | | tement from your hair stylist(s): Written or video statements from your hair stylist(s) licating the amount of hair loss suffered and any lasting effects. | | Yes | No |
| | d | dar | tements from other witnesses: Written or video statements that can testify about the mage to your hair and its effect on you (e.g., spouse, family, friends). Please be sure to lude any witnesses' names and their relationship to you. | | Yes | No |
| | If you | ı do pr | ovide a video statement, it will need to be sent via email to the following: info@curlyhairsettlem | ient.c | om. | |
| | | - | of receipts or other proof of expenses. As detailed above, in order to be reimbursed for any expenses submit copies of receipts or other proof of payment along with your Claim Form. | enses | related to yo | our Claim, |
| | claim would | . Befor | of scalp irritation and/or hair loss suffered and the duration of the hair loss are two critical compressions are and after photographs are often the best resource for demonstrating the amount of hair loss or so provide additional information in the form of a written statement or video, you may also include would be helpful in evaluating your claim. | alp da | amage suffer | red. If you |
| | re | elated | of medical records from medical or mental health providers. If you claim to have seen a doctor to your hair loss and/or scalp irritation, you must obtain your records from your provider is in support of your claim. The Settlement Administrator will not retrieve your medical records. | and s | submit you | |
| | in who lien st UP TO | ole or ubroga O ONE | to have seen a doctor or other medical provider related to your hair loss and/or scalp irritation, you in part, any public or private insurance company that paid for any portion of your relevant treatmetion firm to negotiate these payments. These negotiations take time. THIS WILL LIKELY DELA EYEAR, POTENTIALLY LONGER. To avoid unnecessary delay, DO NOT claim to have seen a edical provider directly in connection with your use of DevaCurl Products. | ent. V Y Y C | We will contr OUR PAYM | ract with a ENT FOR |
| | your l Admi disclo | health nistrat se: al | n to have seen a doctor or other medical provider related to your hair loss and/or scalp irriginsurance plan and/or their agents to release, upon request, certain protected health informat or for the purpose of disclosure and resolution of healthcare and medical liens. This may learn enrollment information, medical records and payment information (including itemization information such as ICD-9/10 codes) related to the injury/illness. Please complete the requirements of the injury in the injury injury in the injury in the injury in the injury in the injury injury in the injury in the injury injury in the injury injury in the injury injury in the injury | ion to y inc ns of | the Settler lude author f said payn | ment Lien rization to ments and |
| 5 | STEF | P TEN | N: ADDITIONAL INFORMATION | | | |
| | | | nan the above, are there any additional costs or damages ted with DevaCurl Products that you are claiming? | | Yes | No |
| | 2. It | f yes, p | please attach copies of the documentation (don't send originals) to this Claim Form. | | | |
| 5 | STEF | PELI | EVEN: DECLARATION | | | |
| Ι | decla | re, uno | ler penalty of perjury, under the laws of the United States, that the information provided in this Cla | aim F | orm is true a | and correct. |
| | | | I purchased, used, and/or had DevaCurl Products used on me between February 8, 2008 and Augustorovided in this Claim Form and all of the documents and information filed in support of this Claim Form and all of the documents and information filed in support of this Claim Form and all of the documents and information filed in support of this Claim Formation filed in support of the s | | | |
| S | Signati | ure: _ | Dated (mm/dd/yyyy): | | | |
| F | rint N | Vame: | | | | |

