

MUST BE
POSTMARKED
NO LATER THAN
JULY 9, 2009



OFFICIAL USE ONLY

**McKESSON SETTLEMENT CONSUMER CASH
PURCHASES CLAIM FORM**

How to Apply For a Payment from the Proposed Settlement.

If you would like to submit a claim in the Proposed Settlement, complete this form and mail it to the address below, along with proof of payment for one or more of the drugs at issue (see Section D below). You may be asked for more information at a later time.

Your claim must be postmarked no later than July 9, 2009.

It should be mailed to:

McKesson Settlement Administrator
c/o Rust Consulting, Inc.
P.O. Box 24607
West Palm Beach, FL 33416

SECTION A – CLAIMANT IDENTIFICATION

Please indicate whether you are claiming on your own behalf as a Class Member or on behalf of someone else who is a Class Member:

- I am the Class Member
- I am the spouse of a deceased Class Member
- I am the legal representative of a deceased Class Member's estate
- I am the legal representative of a minor Class Member

SECTION B – CONTACT INFORMATION

Class Member's Name

Class Member's Birth Date

Applicant Name (if different)

Relationship to Class Member

Street Address

Apartment

City

State

Zip Code

Name of provider(s) who administered the drugs for which you are submitting a claim



SECTION C – PURCHASE INFORMATION

If you purchased one or more of the Subject Drugs in this case without the benefit of insurance or other prescription drug coverage, you may be entitled to part of the settlement. To ensure that your claim is considered, you must provide us with information about the date of purchase of each of these name brand drugs you received and your cost. A listing of the brand-name drugs is attached to the Notice. For a more detailed list of the brand-name drugs, including drug name and description, NDC Code and manufacturer, go to www.McKessonAWPSettlement.com or www.AWPclassactions.com.

If the amount of claims related to the named brand drugs at issue exceeds the funds available to satisfy all cash consumer claims, each cash consumer’s payment will be reduced proportionately.

Drug Name	Date(s) of Purchase	Your Cost
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$

SECTION C – PURCHASE INFORMATION *(continued)*

Drug Name	Date(s) of Purchase	Your Cost
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$
		\$

For additional purchases, please submit on a separate sheet of paper.



SECTION D – PROOF OF PAYMENT

As part of your claim, you must provide proof that you paid for each of the Subject Drugs identified in the chart in Section C without the benefit of insurance or other prescription drug coverage. You only need to provide **one** form of **proof for each** of the **drug(s)**.

Any one of the following are acceptable as proof of payment for one of the drugs. Note that you must provide one of these for each separate drug, but need not submit one for each administration of each drug:

- (1) A receipt, cancelled check, or credit card statement that shows a payment for each of the drugs for which you assert a claim (other than a deductible or co-payment) that was not covered by insurance or other prescription drug coverage; or
- (2) A letter from a doctor saying that he or she prescribed each of the drugs for which you assert a claim and you made a payment for each of the drugs at least once that was not covered by insurance or other prescription drug coverage; or
- (3) A statement signed by you under penalty of perjury in the form supplied (see Section E below) that you made a payment for each of the drugs for which you assert a claim during the period from August 1, 2001 through January 23, 2009 that was not covered by insurance or other prescription drug coverage; or
- (4) Any of the above executed by a spouse of a deceased Class Member or a legal representative of the deceased Class Member's estate.

To the extent that you can obtain any of this information as proof of payment for one or more of the drugs, please do so and include it with this Claim Form.

SECTION E – SWORN STATEMENT REGARDING PAYMENTS MADE

I declare under penalty of perjury that the information provided here is, to the best of my knowledge, correct. I also declare under penalty of perjury that I or the person on whose behalf this claim is submitted paid the full purchase price for one or more of the drugs as indicated in the Claim Form at some time during the period from August 1, 2001 through January 23, 2009 that was not covered by insurance or other prescription drug coverage and did not receive any reimbursement for such purchase(s) from an insurer or health plan. If not submitting this for myself, I am authorized to submit this form on behalf of the Class Member identified above because I am the spouse of a deceased Class Member or the legal representative of a deceased Class Member's estate or the legal representative of a minor Class Member.¹

Signature

Print Name

Date

¹ Please note that your signature on this Claim Form indicates that you declare, under penalty of perjury, that you (or someone on whose behalf you are acting) made a payment for one or more of the drugs at some time during the Class Period that was not covered by insurance or other prescription drug coverage and did not receive any reimbursement for such purchase(s) from an insurer or health plan. As a result, providing false information on this Claim Form could constitute perjury.