

Smith, et al. v. Loyola University Medical Center
Settlement Administrator
P.O. Box 301134
Los Angeles, CA 90030-1134



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VISIT THE SETTLEMENT WEBSITE BY
SCANNING THE PROVIDED QR CODE

*SMITH, ET AL. V. LOYOLA UNIVERSITY
MEDICAL CENTER*

DISTRICT COURT FOR
NORTHERN DISTRICT OF ILLINOIS

Case No. 1:23-cv-15828

**Must Be Postmarked
No Later Than
August 5, 2025**

Claim Form

USE THIS FORM TO MAKE A CLAIM FOR A PRO RATA CASH PAYMENT

The DEADLINE to submit this Claim Form is: August 5, 2025

I. WHAT YOU MAY GET – GENERAL INSTRUCTIONS

If you accessed Loyola University Medical Center’s MyChart patient account portal between January 1, 2018, and December 31, 2022, you are a Settlement Class Member.

As a Settlement Class Member, you are eligible to make a claim for a Cash Payment. Cash Payment amounts may be reduced or increased pro rata (equal share) depending on how many Settlement Class Members submit valid claims. Complete information about the Settlement and its benefits are available at www.LUMCPixelSettlement.com.

This Claim Form must be submitted online at www.LUMCPixelSettlement.com, or completed and mailed to the address below. Please type or legibly print all requested information in blue or black ink. Mail your completed Claim Form, including any supporting documentation, by U.S. mail to:

Smith, et al. v. Loyola University Medical Center
Settlement Administrator
P.O. Box 301134
Los Angeles, CA 90030-1134

Please note: the Settlement Administrator may contact you to request additional documents to process your claim. Your cash benefit may decrease depending on the number and amount of claims submitted.

FOR CLAIMS PROCESSING ONLY	OB <input type="checkbox"/>	CB <input type="checkbox"/>	<input type="checkbox"/> DOC <input type="checkbox"/> LC <input type="checkbox"/> REV	<input type="checkbox"/> RED <input type="checkbox"/> A <input type="checkbox"/> B
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II. CLAIMANT INFORMATION

The Settlement Administrator will use this information for all communications regarding this Claim Form and the Settlement. If this information changes prior to distribution of Cash Payments, you must notify the Settlement Administrator in writing at the address above.

First Name										M.I.		Last Name									
Primary Address																					
Primary Address Continued																					
City										State				ZIP Code							
Foreign Province										Foreign Postal Code						Foreign Country Name/Abbreviation					
Email Address (optional)																					
Area code				Telephone number (home)								Area code				Telephone number (work)					
Claim ID																					

III. REQUEST FOR CASH PAYMENT

Cash Payment. You do not need to submit any additional documents, so long as you provide your Claim ID Number that was provided on your direct notice. A check will be mailed to the address you provided in Section II, above.

I affirm under the laws of the United States that the information supplied in this Claim Form is true and correct to the best of my knowledge and that any documents that I have submitted in support of my claim are true and correct copies of original documentation.

I understand that I may be asked to provide more information by the Settlement Administrator before my claim is complete.

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

Print Name: _____

Questions? Visit www.LUMCPixelSettlement.com or call 1-855-766-4144

**THIS CLAIM FORM MUST BE SUBMITTED OR POSTMARKED BY AUGUST 5, 2025
IN ORDER TO BE TIMELY AND VALID**