Must be received online or postmarked by mail no later than June 7, 2021

UCLA HEAPS SETTLEMENT
C/O JND LEGAL ADMINISTRATION
P.O. BOX 91386
SEATTLE, WA 98111
WWW.UCLAHEAPSSETTLEMENT.COM

UCL

You may submit your Claim Form online at www.UCLAHeapsSettlement.com

TIER 2 AND TIER 3 CLAIM FORM

GENERAL INSTRUCTIONS

Please review the following instructions before proceeding.

You may make a Tier 2 or Tier 3 claim, but not both. In deciding whether to make a Tier 2 or Tier 3 claim, please note:

- To make a Tier 2 or 3 claim, you must fill out Sections 1 through 3, 5 and 6.
- To make a Tier 3 claim, you also need to fill out Section 4, and you will be interviewed by a trained specialist from the Special Master's Team.
- A compensable Tier 2 claim will result in a total award of $12,500 (subject to *pro rata* adjustment).
- A compensable Tier 3 claim will result in a total award of between $12,500 and $250,000, based on an evaluation by the Panel of the information provided in the claim form, during the interview, and in additional evidence of impact or damages.
- The Panel may give a supplemental award in extraordinary cases if the Panel determines that additional compensation is necessary to adequately compensate a claimant who is otherwise eligible to receive the maximum Tier 3 Award. The supplemental award is at the Panel's discretion; you do not need to take any specific action to apply, aside from making a Tier 3 claim.

Please note, if you are a Settlement Class Member, you are eligible for a guaranteed minimum Tier 1 payment regardless of whether you make a Tier 2 or Tier 3 Claim. Please see the Settlement website at **www.UCLAHeapsSettlement.com** for additional information.

SECTION 1: CLAIMANT NAME AND CONTACT INFORMATION

1. NAME:	First	Middle	Last
2. OTHER NAMES USED:			
3. DATE OF BIRTH:	_____ Month _____ Day _____ Year		
4. SOCIAL SECURITY NUMBER, TAXPAYER ID OR FOREIGN ID NUMBER (IF NOT A U.S. CITIZEN):	|___|___|___| - |___|___| - |___|___|___|___| **or** |___|___|___|___|___|___|___|___|___|___|		
5. CURRENT ADDRESS:	Street Address 1		
	Street Address 2		
	City		
	State		
	ZIP Code		
6. PHONE NUMBER:	(|___|___|___|) – |___|___|___| – |___|___|___|___| Area Code		
7. IS IT OKAY TO LEAVE YOU A MESSAGE ON THIS PHONE NUMBER?	**Yes:** ☐ **No:** ☐		
8. EMAIL ADDRESS:			

ATTORNEY REPRESENTATION (IF APPLICABLE)

1. ATTORNEY NAME:	First	M.I.	Last
2. LAW FIRM NAME:			
3. LAW FIRM MAILING ADDRESS:	Street Address 1		
	Street Address 2		
	City		
	State		
	ZIP Code		
4. ATTORNEY TELEPHONE:	(_____) – _____ – _____ Area Code		
5. ATTORNEY EMAIL ADDRESS:			

WHAT IS YOUR PREFERRED LANGUAGE?	

SECTION 2: SELECT CLAIM TYPE

Please select **ONE** of the following claim options:

☐ **Tier 2 Claim** I choose to make a Tier 2 claim and complete this claim form only, to apply for an additional $10,000 award (for a total award of $12,500). I understand the Special Master's Team may contact me in writing about the information provided on the Claim Form and I may be asked to answer questions in writing, but I will not be required to give an interview.

☐ **Tier 3 Claim** I choose to make a Tier 3 claim and complete this claim form, and provide any documentation I have to support my claim, and give a confidential interview to a member of the Special Master's Team to provide as much information as possible about my claim. I understand I may qualify for additional payment for a total award of $12,500 to $250,000. I understand I may also be eligible for a supplemental award.

SECTION 3: QUESTIONS FOR TIER 2 AND 3 CLAIMANTS

Please provide complete responses to the questions below. You may use additional sheets of paper to describe your experiences. If you would like help filling out this Claim Form, Class Counsel are available to help at no cost to you. For assistance from Class Counsel, call 1-888-921-0726 and select Option 8 or email ClassCounsel@UCLAHeapsSettlement.com.

For each date that you were seen by Dr. James Heaps, please answer the questions below. Please be as specific as possible.

1. To the best of your recollection, provide the date(s) and location(s) for each of your appointment(s) with Dr. Heaps.

Date(s):	Location(s):

2. Do you believe Dr. Heaps engaged in sexual misconduct toward you?

Yes: ☐ **No:** ☐

For purposes of this Claim Form, "sexual misconduct" means conduct that is of a sexual nature, and either not medically necessary or not within an acceptable standard of care, including but not limited to sexually suggestive questions, statements, or gestures; touching any part of the body with the hands or with an object for sexual stimulation or gratification; and penetration with the hands or with an object for sexual stimulation or gratification.

3. If yes, list the visit(s) below at which you allege that Dr. Heaps engaged in sexual misconduct toward you.

Date(s):	**Location(s):**

4. For each of the visits at which you allege sexual misconduct occurred, describe the visit in as much detail as possible, including any conduct that you believe was inappropriate and how you felt at the time. Use additional sheets if needed.

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5. Describe how you felt following your appointment(s) with Dr. Heaps, and any continuing impact on you of your appointment(s) with Dr. Heaps.

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6. Did you tell anyone about any of your visits with Dr. Heaps (including friends, relatives, doctors or health professionals, hospital or school administrators, social workers, attorneys, law enforcement authorities, or Praesidium, the counseling service made available through a UCLA hotline after Dr. Heaps was criminally charged)?

Yes: ☐ **No:** ☐

7. If yes, who did you tell and when? What did you tell them about your interaction with Dr. Heaps? Anyone you list will not be contacted without your permission.

Date:		**Name:**	

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Date:		**Name:**	

Date:		**Name:**	

Date:		**Name:**	

8. Did you post any reviews or comments online related to Dr. Heaps?

Yes: ☐ **No:** ☐

9. If yes, list below to the best of your recollection where you made the post, the approximate date, and the general content of the post.

Date:		**Location:**	

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Date:		**Location:**	

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Date:		**Location:**	

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SECTION 4: QUESTIONS FOR TIER 3 CLAIMANTS ONLY

10. When did you first feel that the behavior you described above was inappropriate (e.g., that the behavior made you uncomfortable, that the behavior might have been improper, or that you suspected the behavior could have been medically unnecessary)?

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11. Describe any mental or emotional distress, or physical pain or discomfort, following your appointment(s) with Dr. Heaps up to the present time that were related to your interactions with him. Describe when you began to feel the distress, pain, or discomfort, and how long it lasted.

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12. Describe how any emotional distress or physical pain or discomfort has affected you, including how it has affected your romantic relationship(s) and social functioning, work functioning, or other important aspects of daily life, including impact on sleep, irritability, concentration, eating, and any other activities and emotions, and how that impact has changed over time.

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13. Have you sought counseling in connection with the injuries or emotional distress associated with your visit(s) to Dr. Heaps?

Yes: ☐ **No:** ☐

14. If yes, please describe below. Anyone listed below will not be contacted without your permission.

Date:		**Name of Professional:**	

Nature of Treatment: _____

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Date:		**Name of Professional:**	

Nature of Treatment: _____

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Date:		**Name of Professional:**	

Nature of Treatment: _____

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Date:		**Name of Professional:**	

Nature of Treatment: _____

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Date:		**Name of Professional:**	

Nature of Treatment: _____

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Date:		**Name of Professional:**	

Nature of Treatment: _____

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15. Have you sought other treatment of any kind in connection with the injuries or emotional distress associated with your visit(s) to Dr. Heaps?

Yes: ☐ **No:** ☐

16. If yes, please describe below. Anyone listed below will not be contacted without your permission.

Date:		**Name of Professional:**	

Nature of Treatment: _____

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Date:		**Name of Professional:**	

Nature of Treatment: _____

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Date:		**Name of Professional:**	

Nature of Treatment: _____

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Date:		**Name of Professional:**	

Nature of Treatment: _____

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Date:		**Name of Professional:**	

Nature of Treatment: _____

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Date:		**Name of Professional:**	

Nature of Treatment: _____

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17. If you have incurred any expenses you attribute to injuries or emotional distress caused by your treatment by Dr. Heaps, please itemize such expenses below and, if available, provide copies of supporting documentation.

Expenses:	**Supporting Documents Attached?**
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐
	Yes: ☐ **No:** ☐

18. Please provide any additional information you believe is relevant or useful for the Panel to know.

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SECTION 5: LIENS

As set forth in the Settlement Agreement, the Claims Administrator is administering the process for identifying and resolving any potential Liens that may be withheld or asserted against your Claim Award. If you or the Claims Administrator identifies a potential Lien asserted, and the Claims Administrator confirms the validity and amount of such Lien(s), we are required to deduct those amounts from your Claim Award. For purposes of determining if your Claim Award is subject to a Lien, please fill out the information, where applicable, in this Section.

A. MEDICARE

1. If you are now enrolled, or have been enrolled at any time, in Medicare Part A or Medicare Part B program(s), provide the following information:

   HICN (Medicare Claim #):

   |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

   Enrollment Date: |___|___|/|___|___|/|___|___|___|___|
   (Month/Day/Year)

2. If you are now enrolled, or have been enrolled at any time, in a Medicare Part C program (for example, a Medicare Advantage, Medicare Cost, Medicare healthcare prepayment plan benefits, or similar Medicare plan administered by private entities), provide the following information:

   Name of Plan:

   |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

   Member Number for Plan:

   |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

   Enrollment Date: |___|___|/|___|___|/|___|___|___|___|
   (Month/Day/Year)

3. If you are now enrolled, or have been enrolled at any time, in a Medicare Part D Program (prescription drug benefits), provide the following information:

   Name of Medicare Part D Plan:

   |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

   Member Number of Medical Part D Plan:

   |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

   Enrollment Date: |___|___|/|___|___|/|___|___|___|___|
   (Month/Day/Year)

B. MEDICAID

1. If you are currently enrolled in a state Medicaid Program, provide the following information:

   Medical ID Number: |___|___|___|___|___|___|___|___|___|___|___|___|

   State of Issuance: |___|___|

   Enrollment Date: |___|___|/|___|___|/|___|___|___|___|
   (Month/Day/Year)

2. If you have been enrolled in any other state Medicaid Program at any time, provide the following information:

   Medical ID Number: |___|___|___|___|___|___|___|___|___|___|___|___|

   State of Issuance: |___|___|

   Enrollment Date: |___|___|/|___|___|/|___|___|___|___|
   (Month/Day/Year)

C. DEPARTMENT OF VETERANS AFFAIRS, TRICARE, OR INDIAN HEALTH SERVICE

If you are now enrolled, or have been enrolled at any time, in any of the following programs, provide the required information about each program:

☐ **Department of Veterans Affairs Healthcare or Prescription Drug Benefits**

Claim Number:

|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Enrollment Dates: |___|___|/|___|___|/|___|___|___|___| **TO** |___|___|/|___|___|/|___|___|___|___|
(Month/Day/Year) (Month/Day/Year)

Branch: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Sponsor: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Sponsor SSN: |___|___|___| - |___|___| - |___|___|___|___|

Tribe: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Treating Facility: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

☐ **TRICARE Healthcare or Prescription Drug Benefits**

Claim Number:

Enrollment Dates: ___/___/_____ **TO** ___/___/_____
(Month/Day/Year) (Month/Day/Year)

Branch:

Sponsor:

Sponsor SSN: ___-___-____

Tribe:

Treating Facility:

☐ **Indian Health Service Healthcare or Prescription Drug Benefits**

Claim Number:

Enrollment Dates: ___/___/_____ **TO** ___/___/_____
(Month/Day/Year) (Month/Day/Year)

Branch:

Sponsor:

Sponsor SSN: ___-___-____

Tribe:

Treating Facility:

D. OTHER GOVERNMENTAL PAYOR

If you were entitled to receive medical items, services, and/or prescription drugs from any Federal, State, or other governmental body, agency, department, plan, program, or entity that administers, funds, pays, contracts for, or provides medical items, services, and/or prescription drugs not previously listed above, provide the following information:

Name of Plan/Entity:

Policyholder Name:

Policy Number:

Medical Condition Covered by Plan/Entity:

E. PRIVATE HEALTHCARE INSURANCE

If you have received medical treatment for your injuries described above that were covered by a private healthcare insurance plan, provide the following information for each such plan:

Name of Plan/Entity:

Policyholder Name:

Policy Number:

Medical Condition Covered by Plan/Entity:

F. OTHER LIENS

1. Are you aware of a potential Lien that could be asserted against your Claim Award?

Yes: ☐ **No:** ☐

A "Lien" would include any lien, mortgage, reimbursement claim, pledge, charge, security interest, or other legal encumbrance, of any nature whatsoever, creating a legal obligation to withhold payment of a Claim.

2. If yes, please describe such Liens below:

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SECTION 6: VERIFICATION

I hereby certify that the information provided in this Claim Form, and any attachments, is true and accurate to the best of my knowledge. I authorize the Claims Administrator to contact the healthcare insurance providers identified on this Claim Form per the Settlement Agreement, and I do not object to any resulting disclosures or to the resolution of any potential Liens on my behalf. I understand that the Special Master or her team may contact me regarding the information I provided and that providing false or misleading information may result in the rejection of my Claim.

Claimant Signature	|___|___|/|___|___|/|___|___|___|___| Date (Month/Day/Year)
Printed Full Name (First, Middle, and Last)	

You may submit this Tier 2 or Tier 3 claim by completing this hard copy claim form and mailing it to the Settlement Administrator at UCLA Heaps Settlement, c/o JND Legal Administration, P.O. Box 91386, Seattle, WA 98111 or you may file your claim online through the Settlement Website at www.UCLAHeapsSettlement.com.

Your completed claim must be submitted online or postmarked by mail **no later than June 7, 2021.**