Must be received online or postmarked by mail no later than November 8, 2019.

USC STUDENT HEALTH CENTER SETTLEMENT
C/O JND LEGAL ADMINISTRATION
P.O. BOX 91233
SEATTLE, WA 98111-9333
WWW.USCTYNDALLSETTLEMENT.COM

USC

You may submit your Claim Form Online at www.USCTyndallSettlement.com

TIER 2 AND TIER 3 CLAIM FORM

GENERAL INSTRUCTIONS

Please review the following instructions before proceeding:

Please note that 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 the following:

- To make a Tier 2 or Tier 3 claim, you must describe below your experience, and its impact on you.
- To make a Tier 3 claim, you also need to be interviewed by a specialist from the Panel.
- A compensable Tier 2 claim will result in an award between no less than $7,500 and no more than $20,000 (subject to *Pro Rata* Adjustment);
- A compensable Tier 3 claim will result in an award between no less than $7,500 and no more than $250,000 (subject to *Pro Rata* Adjustment). However, if you decline to participate in the interview you may in no event receive an award which exceeds the Tier 2 Claim Award range between $7,500 and $20,000.

If you wish to submit a Tier 2 or Tier 3 claim, please complete Sections A, C, D, E, F, and sign your name in Section G.

You must also fill out Section B only if you are represented by an attorney.

Please note, if you are a 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.USCTyndallSettlement.com for additional information.

This Claim Form may also be completed online at www.USCTyndallSettlement.com.

THIS INFORMATION IS HIGHLY CONFIDENTIAL AND WILL NOT BE SHARED WITH ANYONE OTHER THAN THE COURT-APPOINTED EVALUATION TEAM AND USC's INSURANCE CARRIERS

SECTION A: CLAIMANT INFORMATION

1. CLAIMANT NAME:	First	Middle	Last
2. FORMER OR MAIDEN NAME (STUDENT NAME):			
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 (including apartment/unit number, if applicable)		
	City		
	State/Province		
	Postal Code		Country
6. TELEPHONE NUMBER:	(|___|___|___|___|) – (|___|___|___|) – |___|___|___|___| – |___|___|___|___| Country Code (if outside the United States) / Area Code / Number		
7. EMAIL ADDRESS:			
8. DATES ENROLLED AT USC:	**From:** _____ Month and Year	**To:** _____ Month and Year	
	School/Department: _____		

9. DATE(S) TREATED IF NOT A STUDENT AT USC:	__/__/____ (MM/DD/YYYY) __/__/____ (MM/DD/YYYY)
10. IS ENGLISH YOUR FIRST LANGUAGE?	**Yes:** ☐ **No:** ☐
11. IF YOU ANSWERED "NO" TO QUESTION 10, WHAT IS YOUR FIRST/NATIVE LANGUAGE?	

SECTION B: ATTORNEY INFORMATION

If you are represented by an attorney, enter the attorney's information in this Section B. (You are only represented by an attorney if you signed a representation agreement or contract hiring that attorney.) If you are not represented by an attorney, skip this section.

1. ATTORNEY NAME:	First	M.I.	Last	Suffix
2. LAW FIRM NAME:				
3. LAW FIRM MAILING ADDRESS:	Address 1			
	Address 2			
	City			
	State/Province			
	Postal Code		Country	
4. ATTORNEY TELEPHONE:	(____) – (____) – ____ – ____ Country Code (if outside the United States) / Area Code / Number			
5. ATTORNEY EMAIL ADDRESS:				

SECTION C: CLAIM SELECTION

Please select **one** of the following two claim options:

☐ **Tier 2 Claim** (I choose only to provide information by filling out this claim form, and understand that may make me eligible for an award of $7,500 to $20,000.)

☐ **Tier 3 Claim** (I choose to provide information by filling out this claim form ***and*** participating in an interview by the Panel, and I understand that may make me eligible for an award of $7,500 to $250,000.)

SECTION D: TREATMENT BY DR. TYNDALL AT USC

Please complete the information below. You may use additional sheets of paper to describe your experiences.

If you need or want any assistance in filling out this Claim Form, the Court has appointed attorneys to represent Class Members, and those attorneys are available at no cost to you to help you. Call 1-888-663-1718 and select Option 8 or email ClassCounsel@USCTyndallSettlement.com.

For each date that you were seen by Dr. George Tyndall, please answer the questions below. *Please be as specific as possible. If you can, please indicate the day, month, and year of your appointment. If you cannot recall the month, please try to recall the season of year (fall, winter, spring, summer). Attach additional pages to describe other visits as necessary.*

VISIT 1

1. Date:

|__|__|/|__|__|/|__|__|__|__|
(MM/DD/YYYY)

2. Facility:

3. Was this your first visit to a gynecologist?

Yes: ☐ **No:** ☐

4. Reason for the appointment you scheduled:

_____

_____

_____

_____

_____

_____

_____

5. What did you expect to be the outcome of this scheduled or walk-in appointment?

6. Did something different happen instead, and if so, what was it?

7. Please describe any discussions you had with the front desk staff at the student health center regarding Dr. Tyndall at the time you scheduled your appointment:

8. Where did you meet with Dr. Tyndall (e.g., in his office, examination room, etc.)?

_____

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Please describe what happened during your appointment with Dr. Tyndall by answering the questions below.

If you need or want any assistance in filling out this Claim Form, the Court has appointed attorneys to represent Settlement Class members, and those attorneys are available at no cost to you to help you. Call 1-888-663-1718 and select Option 8 or email ClassCounsel@USCTyndallSettlement.com.

Please include as much detail as possible regarding Dr. Tyndall's physical examination of you, including your recollection of his procedures, if applicable.

9. Were you asked to disrobe?

Yes: ☐ **No:** ☐

10. If you answered "Yes" above, did you disrobe partially or completely?

Partially ☐

Completely ☐

11. If yes, how did you react to this request at the time it occurred?

_____

_____

_____

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_____

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_____

12. If yes, how do you feel about it now?

_____

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13. What was the stated reason for your removing of clothing when Dr. Tyndall asked you to disrobe?

_____

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14. Did Dr. Tyndall ask you any odd questions? Did Dr. Tyndall make any comments about your body that seemed unprofessional? If so, please describe in as much detail as you are able to accurately recall.

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15. Please describe to the best of your recollection any discussions, remarks, or statements made by Dr. Tyndall. Include what was said by Dr. Tyndall before, during, or after your examination, especially if these comments seemed derogatory, offensive, harassing, or made you feel uncomfortable.

16. Please describe any verbal statements or other demonstrations using gestures, photos, or devices related to alleged sexual education, or descriptions of female or male anatomy, provided by Dr. Tyndall. This might include birth control instructions.

17. Please describe any materials Dr. Tyndall showed or gave you, if applicable.

18. In the process of being examined, were any parts of your body stroked or touched in a manner that made you feel uncomfortable, including, but not limited to, arms, legs, breasts, hair or others?

_____

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19. Please provide detail regarding any prescriptions Dr. Tyndall gave you, whether you requested the prescriptions or they were provided without your request, and the stated purpose of the prescriptions by Dr. Tyndall, if applicable.

_____

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20. Please describe any diagnoses or recommendations for follow-up Dr. Tyndall gave you, and his explanations.

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21. Did Dr. Tyndall make any inappropriate sexual comments (*e.g.*, sexual comments that might have made you feel uncomfortable, or that you believe might have been improper, or suspect could have been medically unnecessary)?

Yes: ☐ **No:** ☐

22. If yes, please describe any such comments. How did you feel about it at the time it occurred?

_____

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23. If yes, how do you feel about it now?

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24. Did Dr. Tyndall digitally penetrate, meaning insert one or more of his fingers into, you vaginally?

Yes: ☐ **No:** ☐

25. If yes, how did you feel about it at the time it occurred?

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26. If yes, how do you feel about it now?

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27. Did Dr. Tyndall, while penetrating you with his finger(s), move his finger(s) in and out?

Yes: ☐ **No:** ☐

28. If yes, how did you react at the time this was occurring?

29. If yes, how do you feel about what happened now?

30. Did Dr. Tyndall anally penetrate you?

Yes: ☐ **No:** ☐

31. If yes, how did you feel about it at the time it occurred?

32. If yes, how do you feel about it now?

_____

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33. Was anyone else present with you and Dr. Tyndall during the visit?

Yes: ☐ **No:** ☐

34. If yes, who was that person (to the best of your recollection)?

_____

_____

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35. Please describe in detail (to the best of your recollection) the role of this person in the visit.

_____

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36. Please describe in detail (to the best of your recollection) any discussions Dr. Tyndall had with this person.

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37. Please describe in detail (to the best of your recollection) any interactions or discussions you had with this person regarding Dr. Tyndall or your visit.

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38. Please describe any discussions you had with anyone at the student health center, after your appointment with Dr. Tyndall concluded, that relate to any concerns or issues that you may have had with your experience with Dr. Tyndall.

_____

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_____

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

_____

_____

_____

_____

_____

_____

_____

_____

40. Did you tell anyone about the conduct you believe was inappropriate (this includes parents, relatives, friends, attorneys, and law enforcement authorities)?

Yes: ☐ **No:** ☐

41. If yes, who did you tell?

_____

_____

_____

_____

_____

_____

42. If yes, what did you say?

_____

_____

_____

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_____

_____

43. If yes, when did you tell this person or people about the inappropriate conduct?

_____

_____

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_____

If you had additional visits, please use separate sheets of paper to answer the same questions for each additional appointment you had with Dr. Tyndall.

SECTION E: IMPACT OF CONDUCT

1. **Describe how you felt during your appointment(s) with Dr. Tyndall. Please include as much detail as possible regarding any physical pain or discomfort, as well as mental or emotional feelings or distress you felt at the time, and why.**

_____

_____

_____

_____

_____

_____

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

_____

_____

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_____

3. Describe how any emotional distress or physical pain or discomfort has affected you and changed over time, including how it has affected your romantic relationship(s) and social functioning, work functioning, or other important aspects of daily life, including for sleep, bathing, irritability, concentration, eating, etc.

_____

_____

_____

_____

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_____

4. Had you had any experiences prior to your visit(s) with Dr. Tyndall that you felt constituted inappropriate sexual behavior or abuse? If so, please describe.

_____

_____

_____

_____

_____

_____

_____

_____

If you need or want any assistance in filling out this Claim Form, the Court has appointed attorneys to represent Settlement Class members, and those attorneys are available at no cost to you to help you. Call 1-888-663-1718 and select Option 8 or email ClassCounsel@USCTyndallSettlement.com.

5. Have you sought counseling by any healthcare professional for your above-referenced injuries or emotional distress?

Yes: ☐ **No:** ☐

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

Date(s) (even if approximate):	**Name(s) of Professional(s):**	**Nature of Treatment:**
__/__/____ (MM/DD/YYYY)		
__/__/____ (MM/DD/YYYY)		
__/__/____ (MM/DD/YYYY)		

6. Have you sought other treatment by any healthcare professional for your above-referenced injuries or emotional distress?

Yes: ☐ **No:** ☐

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

Date(s) (even if approximate):	**Name(s) of Professional(s):**	**Nature of Treatment:**
__/__/____ (MM/DD/YYYY)		
__/__/____ (MM/DD/YYYY)		
__/__/____ (MM/DD/YYYY)		

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

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

SECTION F: LIENS

As set forth in the Settlement Agreement, the Settlement 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 Settlement Administrator identifies a potential Lien asserted, and the Settlement 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.

1. 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)

2. 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)

3. 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: |___|___|/|___|___|/|___|___|___|___| (Month/Day/Year) **TO** |___|___|/|___|___|/|___|___|___|___| (Month/Day/Year)

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

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

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

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

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

☐ **TRICARE Healthcare or Prescription Drug Benefits**

Claim Number:

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

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

4. 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: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

5. 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: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

6. 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 G: SIGNATURE

By signing below, I declare under penalty of perjury, that: (1) all of the information provided in this Claim Form, and any attachments, is true and complete to the best of my knowledge; (2) I authorize the Settlement 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; and (3) I understand that false or misleading information may result in the rejection of my Claim.

Signature Printed Full Name (First, Middle, and Last)	____/____/_____ Date (Month/Day/Year)

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 USC Student Health Center Settlement, c/o JND Legal Administration, P.O. Box 91233, Seattle, WA 98111-9333 or you may file your claim online through the Settlement Website at www.USCTyndallSettlement.com.