

Suncoast Skin Solutions Settlement Administrator  
P.O. Box 3413  
Baton Rouge, LA 70821

**Your Claim Form Must Be Postmarked By  
August 19, 2024**

## ***Reardon, et. al. v. Suncoast Skin Solutions, Inc.***

Circuit Court of the Thirteenth Judicial Circuit in and for Hillsborough County, Florida, Case No. 23-CA-00317

### **Claim Form**

This Claim Form is to be used to apply for benefits related to the Data Incident that Suncoast Skin Solutions, Inc. ("Defendant") discovered on approximately July 14, 2021. There are three (3) types of benefits for which Settlement Class Members may be eligible: (1) compensation for Unreimbursed Out-of-Pocket Losses incurred as a result of the Data Incident, up to a total of \$10,000 per person upon submission of a valid claim and supporting documentation; (2) compensation for up to four (4) hours of Lost Time, at \$25.00/hour (\$100 cap), for time spent mitigating the effects of the Data Incident. Claims for Lost Time can be combined with claims for Unreimbursed Out-of-Pocket Losses; and (3) two (2) years of Medical Shield Complete medical and credit monitoring services. To receive these benefits, Settlement Class Members must submit a signed, valid Claim Form. In the event that the total amount of Approved Claims exceeds the amount of the Net Settlement Fund, then the cash Settlement Payments to be paid for Approved Claims shall be proportionately reduced on a pro rata basis and paid in accordance with the terms and conditions of the Settlement Agreement.

To submit a claim, you must be a Settlement Class Member whose Personal Information was potentially compromised in the Data Incident and/or received Notice of this settlement with a Settlement Claim ID.

**Please be advised that any supporting documentation that you would like to provide must be submitted with this Claim Form.** If you have questions about this Claim Form, please visit the Settlement Website at [www.SuncoastSettlement.com](http://www.SuncoastSettlement.com) for additional information. Failure to submit required documentation, or to complete all parts of the Claim Form, may result in denial of the claim, delay its processing, or otherwise adversely affect the claim.

**PLEASE KEEP A COPY OF YOUR CLAIM FORM, SUPPORTING DOCUMENTATION, AND PROOF OF MAILING FOR YOUR RECORDS.**

### **A. Class Member Name and Contact Information**

Provide your name and contact information below. You must notify the Settlement Administrator if your contact information changes after you submit this form.

_____	_____	
First Name*	Last Name*	
_____		
Mailing Address: Street Address/P.O. Box (include Apartment/Suite/Floor Number)*		
_____		
_____	_____	_____
City*	State*	Zip Code*
_____		
Email Address*		
_____		
_____	_____	
Telephone Number*	Settlement Claim ID*	

## B. Reimbursement for Out-of-Pocket Losses

Check this box if you suffered verifiable financial losses as a result of the Data Incident.

If it is verified that you meet all the criteria described in the Settlement Agreement, **and you submit documentation** that proves your losses and the dollar amount of those losses, you are eligible to receive a payment compensating you for your documented Out-of-Pocket Losses of up to **\$10,000 per person**. Out-of-Pocket Losses includes: (1) unreimbursed costs, expenses, losses or charges incurred a result of identity theft or identity fraud, falsified tax returns, or other possible misuse of Class Member's Personal Information; (2) costs associated with accessing or freezing/unfreezing credit reports with any credit reporting agency; (3) expenses involving notary, fax, postage, copying, mileage, and long-distance telephone charges; (4) costs associated with credit monitoring or identity theft insurance or other mitigative costs if incurred as a result of the Incident; and (5) unpaid time off work to address issues fairly traceable to the Incident at the actual hourly rate of that class member.

**Providing adequate proof of your losses does not guarantee that you will be entitled to receive the full amount claimed. All claims will also be subject to an aggregate maximum payment amount, as explained in the Settlement Agreement. If the amount of losses claimed exceeds the maximum amount of money available under the Settlement Agreement, then the payment for your claim will be reduced on a pro rata basis. If you would like to learn more, please review the Settlement Agreement for further details.**

For each loss that you believe was incurred as a result of the Data Incident, please provide a description of the loss, the date of the loss, the dollar amount of the loss, and all documentation that supports the loss. **You must provide ALL this information for this claim to be processed.** Supporting documents must be submitted with this Claim Form.

**If you fail to provide sufficient supporting documents, the Settlement Administrator will deny your claim.** Please provide only copies of your supporting documents and keep all originals for your personal files. The Settlement Administrator will have no obligation to return any supporting documentation to you. A copy of the Settlement Administrator's privacy policy is available at <https://www.SuncoastSettlement.com/privacy-policy/>. Please do not directly communicate with Defendant regarding this matter. All inquiries are to be sent to the Settlement Administrator.

Description of Loss	Date of Loss (MM/DD/YY)	Amount of Loss	Documentation Description
<i>Example: Identity Theft Protection Service</i>	07 / 17 / 20	\$ 50.00	<i>Copy of identity protection service bill</i>
<i>Example: fees paid to a professional to remedy a falsified tax return</i>	02 / 28 / 21.	\$ 25.00	<i>Copy of the professional services bill</i>
	/ /	\$	
	/ /	\$	
	/ /	\$	
	/ /	\$	
	/ /	\$	
	/ /	\$	
	<b>TOTAL AMOUNT CLAIMED:</b>	\$	

## C. Reimbursement for Lost Time

Class Members may submit a claim for up to four (4) hours of time spent remedying issues related to the Data Incident. Four (4) hours of lost time may be reimbursed at \$25 per hour (\$100 cap) if you provide an attestation as to the time you spent remedying issues related to the Data Incident.

Examples of lost time spent remedying issues related to the Data Incident may include time spent remedying identity theft, fraud, misuse of private information, credit monitoring, or freezing credit reports.

**Yes, I understand that I am submitting this Claim Form and the affirmation it makes as to my seeking relief for Lost Time under penalty of perjury. I further understand that failure to check this box may render my Claim for Lost Time null and void.**

Hours spent remedying issues related to the Data Incident (4 hour maximum)  hours

### **D. Credit Monitoring Services**

Class Members are eligible to enroll in two (2) years of Medical Shield Complete medical and credit monitoring services.

By checking the below box, I choose to enroll in Credit Monitoring Services.

Yes, I choose to enroll in Credit Monitoring Services.

### **E. Payment Options**

Settlement Class Members whose claim forms are determined to be timely and valid will receive their cash payments via an electronic payment method or by check. Please ensure you provide a current, valid email address in Section I of this claim form. If the email address you include with your submission becomes invalid for any reason, it is your responsibility to provide accurate contact information to the Settlement Administrator to receive a payment.

Please select from **one** of the following payment options:

**Venmo**

\_\_\_\_\_  
Venmo Account Email Address or Phone Number

**Zelle**

\_\_\_\_\_  
Zelle Account Email Address or Phone Number

**PayPal**

\_\_\_\_\_  
PayPal Account Email Address or Phone Number

**E-MasterCard**

\_\_\_\_\_  
Your Current Email Address

**Physical Check:** Payment will be mailed to the address provided in Section A above.

### **F. Class Member Affirmation**

By submitting this Claim Form, I certify that I am eligible to make a claim in this settlement and that the information provided in this Claim Form and any attachments are true and correct. I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct. I understand that this claim may be subject to audit, verification, and Court review and that the Settlement Administrator may require supplementation of this Claim or additional information from me. I also understand that all claim payments are subject to the availability of settlement funds and may be reduced in part or in whole, depending on the type of claim and the determinations of the Settlement Administrator.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date