

IF YOU ARE A CURRENT RESIDENT OF A SALMON HEALTH FACILITY YOU DO NOT NEED TO FILL OUT A CLAIM FORM.

THE CLAIM FORM IS ONLY FOR FORMER RESIDENTS OF A SALMON HEALTH ASSISTED LIVING FACILITY

CLASS ACTION CLAIM AND CERTIFICATION FORM

JOEL BURMAN AS THE LEGAL REPRESENTATIVE OF THE ESTATE OF MARY BURMAN, et al.

v.

CONTINUING CARE MANAGEMENT LLC; WHITNEY PLACE AT SHARON LLC; WHITNEY PLACE AT SHARON LIMITED PARTNERSHIP, D/B/A WHITNEY PLACE AT SHARON; WHITNEY PLACE AT SHARON MANAGEMENT LLC; SALMON HEALTH AND RETIREMENT; AND SHI II WHITNEY PLACE SHARON, LLC.

**Worcester Superior Court
Civil Action No. 2085-CV-00971D**

Please provide your current contact information below:			
Name:	_____		
Address:	_____		
City:	_____	State:	_____ Zip: _____
Phone:	_____		
Email:	_____		

I. INSTRUCTIONS

To submit a Claim for a payment from the Settlement Claim Fund on behalf of yourself, please fill out the Claim Form below and submit it by U.S. mail to the address for the Settlement Administrator listed below. You may also file a Claim Form online at www.SalmonHealthALRSettlement.com.

THE DEADLINE TO FILE A CLAIM ONLINE SHALL EXTEND UNTIL 11:59 PM ON THE TWENTY-EIGHTH DAY (4 WEEKS) FROM THE DATE OF FINAL APPROVAL. IF YOU SEND IN A CLAIM FORM BY REGULAR MAIL, IT MUST BE POSTMARKED ON OR BEFORE THE TWENTY-EIGHTH DAY (4 WEEKS) FROM THE DATE OF FINAL APPROVAL.

**Salmon Health ALR Settlement Program
BrownGreer PLC – Settlement Administrator
P.O. Box 25277
Richmond, VA 23260
1-833-520-3800
Questions@SalmonHealthALRSettlement.com**

II. INFORMATION REGARDING THE CLASS ACTION SETTLEMENT

Information regarding the Class Action Settlement was provided to you in the *Notice of Proposed Class Action Settlement*. The Notice, along with other relevant court documents and other information regarding the lawsuit, and proposed settlement, are also available at www.SalmonHealthALRSettlement.com.

Any questions can be addressed to the Settlement Administrator at the address listed.

III. AUTHORIZED REPRESENTATIVE INFORMATION

If the Class Member to whom this Claim Form is addressed is deceased, and the person responding is doing so in capacity as a representative of the estate, please provide the following information:

Name:	First	Middle Initial	Last
Mailing Address:	Street/P.O. Box		
	City	State	Zip Code
Email Address:		Telephone Number	(_____) _____ - _____
Nature of Representative Capacity (executor, administrator, etc.):			
Probate Docket No. (if any):			

PLEASE ATTACH DOCUMENTATION OF YOUR AUTHORITY TO SO ACT (E.G. NOTICE OF APPOINTMENT AS PERSONAL REPRESENTATIVE OF THE ESTATE).

IN THE EVENT THE CLASS MEMBER IS DECEASED, THE SETTLEMENT ADMINISTRATOR MAY REQUIRE THE ESTATE INFORMATION BEFORE DISTRIBUTION IS MADE.

HOWEVER, THIS DOES NOT PRECLUDE THE FILING OF THIS CLAIM FORM.

CERTIFICATION

I, the undersigned, hereby certify, under the pains and penalties of perjury, that to the best of my knowledge and information, the information provided in the Claim Form is true and correct and that I am authorized to assert this Claim.

Signed, under pains and penalties of perjury, this ____ day of _____, 2023.

Signature: _____

Print Name: _____

THIS CLAIM FORM MUST BE POSTMARKED OR RECEIVED BY THE SETTLEMENT ADMINISTRATOR NO LATER THAN TWENTY-EIGHT DAYS FROM THE DATE OF FINAL APPROVAL.