FOR OFFICIAL USE ONLY

Staley, et al. v. Gilead Sciences, Inc., et al.
Case No. 3:19-cv-02573-EMC

CONSUMER PROOF OF CLAIM

YOUR CLAIM MUST BE POSTMARKED OR SUBMITTED ONLINE WITHIN 60 DAYS OF THE FINAL APPROVAL. THE FINAL APPROVAL HEARING IS APRIL 28, 2022. YOU MAY CHECK THE WEBSITE, WWW.HIVDRUGSETTLEMENT.COM, TO SEE WHETHER THE COURT HAS APPROVED THE SETTLEMENT

Submit the Proof of Claim form using the Settlement Administrator's website, www.HIVdrugsettlement.com

OR

Mail your claim to:

Staley, et al. v. Gilead Sciences, Inc., et al.
c/o A.B. Data, Ltd.
P.O. Box 173017
Milwaukee, WI 53217

ATTENTION: THIS FORM IS ONLY TO BE FILLED OUT BY CONSUMERS.

Section A: Claimant Identification

Claimant's Name

Agent/Legal Representative

Street Address

City | State | Zip

Mobile Telephone Number | Email Address*

*By providing your email address, you authorize the Settlement Administrator to use it in providing you with information relevant to this claim.

Section B: Should I File a Claim Form?

In order to be eligible to file a claim form and receive a cash distribution from the proposed Settlement, you must be either

a) a person residing in the United States or its territories who purchased and paid for some or all of the purchase price of branded or generic Atripla in Alabama, Arizona, Arkansas, California, Connecticut, District of Columbia, Florida, Hawaii, Idaho, Illinois, Iowa, Kansas, Maryland, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Oregon, Rhode Island, South Dakota, Tennessee, Utah, Vermont, West Virginia, or Wisconsin (the "Damages States") for the

purpose of consumption by yourself or your family member(s) at any time between May 14, 2015 through and until October 13, 2021; **OR**

b) a person residing in the United States or its territories who purchased and paid for some or all of the purchase price of Evotaz in any of the Damages States (*see Section B, (a) for a list of Damages States*) for the purpose of consumption by yourself or your family member(s) at any time between May 14, 2015 through and until October 13, 2021.

Several groups are excluded from the Class and are not eligible to file a claim form and receive a cash distribution from the proposed Settlement, even if they otherwise meet the definition above. The following groups are excluded from the Class:

a. Any person who is an officer, director, management, employee, subsidiary, or affiliate of: Gilead Sciences, Inc., Gilead Holdings, LLC, Gilead Sciences, LLC, or Gilead Sciences Ireland UC; Bristol-Myers Squibb Company or E. R. Squibb & Sons, L.L.C.; or Johnson & Johnson, Janssen Products LP, or Janssen R&D Ireland (together, the "Defendants");

b. A judge in this case or a member of his or her immediate family; or

c. Any person who has previously opted out of the Classes in this case.

☐ By checking this box, I confirm that I have read the definition of the Class and I am not excluded from participating in the proposed Settlement. DO NOT SUBMIT A CLAIM FORM IF YOU DO NOT MEET THE DEFINITIONS ABOVE.

Section C: Purchase Information

a) Provide the total amount of your out-of-pocket expenditures for purchases you made in any of the Damages States (*see Section B, (a) on page 1 for list of Damages States*), while you resided in the United States or its territories, of branded or generic Atripla between May 14, 2015 through and until October 13, 2021:

Total amount of out-of-pocket expenditures you paid for the brand or generic Atripla purchases identified above:	$

b) Provide the total amount of your out-of-pocket expenditures for purchases you made in any of the Damages States (*see Section B, (a) on page 1 for list of Damages States*), while you resided in the United States or its territories, of branded Evotaz between May 14, 2015 through and until October 13, 2021:

Total amount of out-of-pocket expenditures you paid for the brand Evotaz purchases identified above:	$

Were the purchases identified above made using some form of insurance benefit that covered some of the costs of those purchases: Yes _______ No _______ (please check one).

If you used some form of insurance benefit, identify the name(s) of one or more of your insurer(s):____

____

Section D: Note Regarding Documentation

You do not need to provide any documentation at this time. However, the Settlement Administrator may ask for additional proof supporting your claim. Any one of the following is acceptable as claim documentation for the purchase information set forth in Section C above, if requested by the Settlement Administrator:

1. Itemized receipts that show payment(s) for the subject drugs; or
2. An EOB (explanation of benefits) from your insurer that shows you paid for the subject drugs; or
3. Records from your pharmacy showing that you paid for the subject drugs; or

4. Copies of records showing prescriptions written for the subject drugs.

If the Settlement Administrator contacts you for requested documentation, failure to respond or provide sufficient documentation may result in the reduction or rejection of your claim.

Section E: Certification

I have read and am familiar with the contents of this Proof of Claim. I certify that the information I have set forth above is true, correct, and complete to the best of my knowledge. I certify that I, or the Class Member I represent, paid the total amount set forth above in out-of- pocket expenditures for purchases of brand or generic Atripla between May 14, 2015 through and until October 13, 2021, in one or more of the Damages States while residing in the United States and its territories, or for purchases of brand Evotaz between May 14, 2015 through and until October 13, 2021, in one or more of the Damages States while residing in the United States and its territories. I further certify that I, or the Class Member I represent, did not opt out of the certified Class in this Action. Nor did I, or the Class Member I represent, purchase such branded or authorized generic versions of brand or generic Atripla or brand Evotaz for purposes of resale.

In addition, I: (1) have not (or the represented Class Member has not) served as an officer, director, management, employee, subsidiary, or affiliate of Gilead Sciences, Inc., Gilead Holdings, LLC, Gilead Sciences, LLC, or Gilead Sciences Ireland UC; Bristol-Myers Squibb Company or E. R. Squibb & Sons, L.L.C.; or Johnson & Johnson, Janssen Products LP, or Janssen R&D Ireland (together, the "Defendants"); (2) did not opt out of the Classes; and (3) am not one of the judges in this case or a member of their immediate families.

To the extent I have been given authority to submit this Proof of Claim by a Class Member on his or her behalf, and accordingly am submitting this Proof of Claim in the capacity of an authorized agent, and to the extent I have been authorized to receive on behalf of this Class Member(s) any and all amounts that may be allocated to him or her from the Settlement Fund, I certify that such authority has been properly vested in me and that I will fulfill all duties I may owe the Class Member. In the event amounts from the Settlement Fund are distributed to me and a Class Member later claims that I did not have the authority to claim and/or receive such amounts on its behalf, I and/or my employer will hold the Class, counsel for the Class, and the Settlement Administrator harmless with respect to any claims made by the Class Member.

I hereby submit to the jurisdiction of the United States District Court for the Northern District of California, San Francisco Division for all purposes connected with this Proof of Claim, including resolution of disputes relating to this Proof of Claim. I acknowledge that any false information or representations contained herein may subject me to sanctions, including the possibility of criminal prosecution. I agree to supplement this Proof of Claim by furnishing documentary backup for the information provided herein, upon request of the Settlement Administrator.

I certify that the above information supplied by the undersigned is true and correct to the best of my knowledge and that this Proof of Claim form was executed this ________ day of ____________________, 202_.

Signature	Print or Type Name

If you have not completed this Claim Form online and submitted it electronically through the Settlement Administrator's website, you must mail the completed Claim Form postmarked within 60 days of the final approval. The Final Approval Hearing is April 28, 2022, to the following address:

Staley, et al. v. Gilead Sciences, Inc., et al.
c/o A.B. Data, Ltd.
P.O. Box 173017
Milwaukee, WI 53217

Toll-Free Telephone: 1 -877-999-2491 Website: www.HIVdrugsettlement.com

REMINDER CHECKLIST:

1. Please complete and sign the above Proof of Claim form. Attach or upload any documentation supporting your claim if you choose to submit documentation with your claim.

2. Keep a copy of your Proof of Claim form and supporting documentation for your records.

3. If you would also like acknowledgement of receipt of your Proof of Claim form, please complete the form online or mail this form via Certified Mail, Return Receipt Requested.

4. If you move and/or your name changes, please send your new address and/or your new name or contact information to the Settlement Administrator via the Settlement website or U.S. Mail (the addresses are listed above).