EXHIBIT "E"

EXHIBIT "E"

CONFIDENTIAL
Proposed Smirk's-Molinos Settlement
c/o Ed Gentle, Settlement Administrator
501 Riverchase Parkway East, Suite 100
Hoover, AL 35244
(800) 345-0837 Toll Free | (205) 716-3000 Telephone
(205) 716-2364 Facsimile

CLAIM FORM
FOR PROPOSED SMIRK'S-MOLINOS SETTLEMENT

1. CLAIMANT IDENTIFICATION

Name: ______________________________

Date of Birth: ______________________________

Social Security No: ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip: __________ County: ______________

If you have filed a lawsuit, arbitration, or other proceeding involving consumption of Daily Harvest's Lentil + Leek Crumbles (the "Crumbles"), state the case name, venue, and docket number: ____________
____

If you are filing this claim as a legal representative for the Claimant state your name here, followed by the basis of your authority (*e.g.,* Power of Attorney, Parent or Legal Guardian, Conservator):
____

If you are represented by legal counsel in connection with consumption of Crumbles, state the name, address, telephone number, and email address of that counsel:
____

2. EXPOSURE

Date(s) on which Claimant purchased the *French Lentil + Leek Crumbles ("Crumbles")*, if applicable:
____

Date(s) on which claimant ate the Crumbles, if applicable: ______________________________

Does claimant possess a proof of purchase for the Crumbles? ☐ YES ☐ NO

Did claimant pay for the Crumbles with a credit/debit card? ☐ YES ☐ NO

Did someone else pay for the Crumbles with a credit/debit card? ☐ YES ☐ NO

If someone else paid for the Crumbles, identify that person: ______________________________

3. ILLNESS

Did Claimant experience an injury? ☐ Yes ☐ No

Date of symptom onset: ______________

Which, if any, of the following did claimant experience after eating the Crumbles?

Itching	☐ Yes	☐ No	Fatigue	☐ Yes	☐ No
Nausea	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No
Vomiting	☐ Yes	☐ No	Dark Urine	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Loss of appetite	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Stomach cramps	☐ Yes	☐ No
Fever/Chills	☐ Yes	☐ No	Light colored stool	☐ Yes	☐ No
Pain	☐ Yes	☐ No	Abnormal liver function by lab testing	☐ Yes	☐ No
Muscle/body aches	☐ Yes	☐ No			

Did Claimant experience any other symptoms? If so, please describe them:

____

____

Was Claimant treated by a doctor? ☐ Yes ☐ No

Was Claimant treated in the Emergency Room? ☐ Yes ☐ No
If so, number of ER visits: ____________

Was Claimant admitted to the hospital? ☐ Yes ☐ No
If so, how many nights in the hospital: ________

Did Claimant undergo any diagnostic or medical procedures? ☐ Yes ☐ No
If so, please list: ____

Did Claimant undergo a cholecystectomy? ☐ Yes ☐ No

Date Claimant's symptoms resolved: ____________________

If Claimant's symptoms have not resolved, please describe any ongoing symptoms and medical care:

____

____

____

____

____

____

4. CATEGORY DESIGNATION

In this section, please check the category that applies to your Claim

______ **Category 1A:** Claimant did not mark any illnesses in Section 3, and only suffered consequential monetary damages arising from or related to another person's alleged personal injuries arising from the consumption of the Crumbles.

______ **Category 1B:** Claimant did not receive medical treatment for personal injury illnesses marked in Section 3.

______ **Category 2:** Claimant received medical treatment for illnesses marked in Section 3, but was not hospitalized.

______ **Category 3:** Claimant received medical treatment for illnesses marked in Section 3, and was hospitalized. (Emergency Room visits are not considered hospitalizations. Claimant must have been admitted to the hospital to qualify for this Category).

______ **Category 4:** Claimant received medical treatment for illnesses marked in Section 3, including hospitalization related to a cholecystectomy.

If you received medical treatment for your injuries and would like to be considered for an enhancement of your monetary benefits, please identify any special medical circumstances of your illness that should be considered in evaluating the claim: (Please note, that only Claimants who can show they received medical treatment for illnesses in Categories 2, 3, or 4 above, are eligible for an enhancement consideration.)

____

____

____

____

____

5. MEDICAL PROVIDERS

(If Claimant checked Category 1, skip to Section 6)

Please list all medical providers that claimant received related medical treatment from.

Provider Name: ____

Address: ____

Dates of Treatment: ____

Charges: ____

Provider Name: ____

Address: ____

Dates of Treatment: ____

Charges: ____

Provider Name: ____

Address: ____

Dates of Treatment: ____

Charges: ____

Provider Name: ____

Address: ____

Dates of Treatment: ____
Charges: ____

Provider Name: ____

Address: ____

Dates of Treatment: ____
Charges: ____

Provider Name: ____

Address: ____

Dates of Treatment: ____
Charges: ____

Provider Name: ____

Address: ____

Dates of Treatment: ____
Charges: ____

Provider Name: ____

Address: ____

Dates of Treatment: ____
Charges: ____

Provider Name: ____

Address: ____

Dates of Treatment: ____
Charges: ____

Provider Name: ____

Address: ____

Dates of Treatment: ____
Charges: ____

6. MEDICAL EXPENSES

Total medical expenses claimed: $_____________ (Please attach medical bills to support)

7. RETAINED EXPERT OR TREATING PROVIDER REPORT? ☐ Yes ☐ No

If so, please attach report(s).

I declare under penalty of perjury of the laws of the State of ____________________ that the information provided in this Proof of Claim Form and the attachments hereto is true and correct to the best of my knowledge.

____

Claimant or Representative Signature

SUBMITTED ON _________________, 2024 ____
Counsel for Claimant

REQUIRED DOCUMENTATION

Please tab and attach:

1. All medical records, including laboratory reports, of claimant relating in any way to the illness or any special medical circumstances of claimant's illness described in Section 4, and (optional) chronology of medical care.

2. All medical bills, liens, receipts and notices of payment due related to the illness.

3. Proof of purchase for *Crumbles* (i.e. receipt, credit card, or bank statement).

4. Evidence related to any special circumstances claimed.

5. Report of retained expert(s) or treating healthcare provider(s) regarding claimant's illness.

Exhibit E.1

MEDICAL INSURANCE BENEFITS QUESTIONNAIRE

PLEASE MAKE SURE THAT YOU COMPLETE & RETURN ALL PAGES OF THIS FORM, INCLUDING COPIES OF INSURANCE CARDS AND ADDITIONAL PAGES, IF NEEDED.

MISSING OR ILLEGIBLE INFORMATION AND/OR PAGES WILL DELAY THE PROCESSING OF YOUR CLAIM.

MEDICAL INSURANCE BENEFITS QUESTIONNAIRE

GENTLE, TURNER & BENSON, LLC
501 RIVERCHASE PARKWAY EAST, SUITE 100
HOOVER, ALABAMA 35244
TOLL FREE (800) 345-0837 ● LOCAL (205) 716-3000 ● FAX (205) 716-2364
OUR FILE NO. 6890-2

I. PERSONAL INFORMATION FOR THE INJURED PARTY– If you are completing this form on behalf of an injured party (as parent, guardian, representative, POA, GAL, etc.), **complete this entire form using information for the INJURED PARTY and attach a copy of the documentation designating you as such.**

Full LEGAL Name of INJURED PARTY: ______________________________
(First) (M.I.) (Last)

Current Address or Address at Time of Death: ______________________________

City: ______________________ State: ________ Zip: ____________

Date of Birth: ____________ Full SSN: ______________ Telephone: (____)____________
mm/dd/year **(Required)**

Email Address: ______________________________ Gender: **M** ☐ **F** ☐

Is the injured party deceased? YES ☐ **NO** ☐ If "Yes", date of death: ______________

II. SETTLEMENT INJURY INFORMATION (if unsure, please get this information from your attorney)

For the purpose of this questionnaire, the term "injury" refers to the event that qualified the injured party for the potential settlement.

Date of 1st ingestion of Daily Harvest (can be approximate): ______________________

Onset date of injury symptoms/illness allegedly caused by the Crumbles: ______________

CITY, STATE AND COUNTY where injury occurred: ______________________________
CITY STATE COUNTY

III. GOVERNMENT MEDICAL INSURANCE INFORMATION

MEDICARE: ***Federally sponsored*** medical insurance benefits for most people aged 65 years or older or who have been on social security disability for more than 24 consecutive months

From the date of the injury to present day, did the injured party become eligible for *MEDICARE* parts A &/or B benefits? (please answer regarding eligibility to receive original Medicare benefits even if the injured party has a Medicare replacement plan in effect) YES ☐ **NO** ☐

If 'Yes', on what date did the injured party become eligible for Medicare? ______________

Please list the injured party's Medicare number (HICN or MBI): ______________________

********PLEASE ATTACH A COPY OF THE RED, WHITE & BLUE MEDICARE CARD********

MEDICAID: ***State sponsored, needs-based*** medical insurance benefits. The injured party may have applied for this insurance coverage through a state or county office. Please note: The insurance received through this application process may not be called "Medicaid", but it is considered Medicaid for the purposes of this settlement.

State Medicaid agencies sometimes will provide your medical insurance through a **Managed Care Organization/Plan ("MCO")**. MCOs are still considered Medicaid plans. Examples of common Medicaid MCOs are Wellcare, Molina, United Healthcare, Amerigroup, MercyCare, AETNA Better Health, etc., but there are many Medicaid MCO plans and they are not limited to the previous examples. Your insurance card may provide information as to whether your plan is a Medicaid MCO.

From the date of the injury to present day, did the injured party become eligible for *MEDICAID* medical insurance benefits, including MCOs, in any state? YES ☐ NO ☐

If 'Yes', please list all states through which the injured party received Medicaid medical insurance since the settlement injury and any corresponding MCO(s) for each state:

State 1. ____________________ MCO(s), if any: ______________________________

State 2. ____________________ MCO(s), if any: ______________________________

State 3. ____________________ MCO(s), if any: ______________________________

State 4. ____________________ MCO(s), if any: ______________________________

State 5. ____________________ MCO(s), if any: ______________________________

*********PLEASE ATTACH A COPY OF MEDICAID AND/OR MCO CARDS*********

TRICARE (formerly known as CHAMPUS) or US Family Health Plan: Medical insurance through the U.S. Armed Forces

From the date of your injury to present day, did the injured party receive medical insurance through his/her own service or a family member's service in any branch of the U.S. Armed Forces? YES ☐ NO ☐

If 'Yes', please answer the following questions:

1. Is the injured party the Sponsor or a Dependent? (circle one) **SPONSOR** **DEPENDENT**

2. If a dependent, list the **Sponsor's** Name and ID number:

______________________________ ______________________________
Sponsor Full Name Sponsor ID Number

3. In what branch of the Armed Forces did the sponsor serve? Please check the branch in which the sponsor most recently served:

Army ☐ **Army National Guard** ☐ **Army Reserves** ☐ **Navy** ☐

Naval Reserves ☐ **Marines** ☐ **Marine Reserves** ☐ **Air Force** ☐

Air National Guard ☐ **U.S. Coast Guard** ☐ **US Public Health Services** ☐

VETERANS ADMINISTRATION MEDICAL BENEFITS:

1. From the date of the injury to present day, did the injured party become eligible to receive ANY medical treatment (not just service connected treatment) from a *Veterans Administration ("VA") hospital or any other VA medical facility*? YES ☐ NO ☐

If 'Yes', please list the names and locations (city and state) of <u>all</u> VA treatment facilities from which the inured party received <u>ANY</u> medical treatment, <u>even if the medical treatment is not related to this case and even if he/she did not seek medical treatment at a VA facility for settlement related injuries</u>. (attach additional pages, if needed):

1. ______________________________ ______________________________
Facility Name City, State

2. ______________________________ ______________________________
Facility Name City, State

3. ______________________________ ______________________________
Facility Name City, State

4. ______________________________ ______________________________
Facility Name City, State

2. From the date of the injury to present day, did the injured party become eligible to receive CHAMPVA coverage (VA coverage for dependents of disabled or deceased Veterans)? YES ☐ NO ☐

If 'Yes", please list the names and locations (city and state) of <u>all</u> VA treatment facilities from which the injured party received <u>ANY</u> medical treatment, <u>even if the medical treatment is not related to this case</u> (attach additional pages, if needed):

1. ______________________________ ______________________________
Facility Name City, State

2. ______________________________ ______________________________
Facility Name City, State

3. ______________________________ ______________________________
Facility Name City, State

4. ______________________________ ______________________________
Facility Name City, State

INDIAN HEALTH SERVICE:

From the date of the injury to present day, has the injured party been eligible to receive medical care from Indian Health Service? YES ☐ NO ☐

If 'Yes', please list the IHS facility from which you received settlement-related medical care and the address and phone number of the facility:

____

____

IV. PRIVATE MEDICAL INSURANCE INFORMATION

PRIVATE MEDICAL INSURANCE: Medical insurance received through the injured party's or a family member's employment or an individual medical insurance plan purchased directly from a medical insurance company or through the insurance marketplace. Private health insurance also includes any Medicare Parts C &/or D plans, ANY Medicare Advantage or Medicare supplement plans, and prescription only plans.

Did the injured party have private medical insurance at the time of or at any time since the injury?
YES ☐ **NO** ☐

If 'Yes', list ALL private medical insurance coverage the injured party had from the date of the injury to present day:

1. Insurance company name: ____________________

Member, plan, contract, etc. ID #: ____________ Group #: ____________

Insurer's Member Services phone #: (may be found on the back of the insurance card): ____________

Is this a Medicare Advantage or Medicare supplement plan? YES ☐ **NO** ☐

\- - - - - - - - - - - - - - - - -

2. Insurance company name: ____________________

Member, plan, contract, etc. ID #: ____________ Group #: ____________

Insurer's Member Services phone #: (may be found on the back of the insurance card): ____________

Is this a Medicare Advantage or Medicare supplement plan? YES ☐ **NO** ☐

\- - - - - - - - - - - - - - - - -

3. Insurance company name: ____________________

Member, plan, contract, etc. ID #: ____________ Group #: ____________

Insurer's Member Services phone #: (may be found on the back of the insurance card): ____________

Is this a Medicare Advantage or Medicare supplement plan? YES ☐ **NO** ☐

4. Insurance company name: ____________________

Member, plan, contract, etc. ID #: ____________ Group #: ____________

Insurer's Member Services phone #: (may be found on the back of the insurance card): ____________

Is this a Medicare Advantage or Medicare supplement plan? YES ☐ **NO** ☐

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*******PLEASE ATTACH A COPY OF THE FRONT & BACK OF THE INSURANCE CARD(S)*******

PRIVATE MEDICAL INSURANCE, CONT.

5. Insurance company name: ______________________________

Member, plan, contract, etc. ID #: ____________________ Group #: ________________

Insurer's Member Services phone #: (may be found on the back of the insurance card): ________________

Is this a Medicare Advantage or Medicare supplement plan? YES ☐ NO ☐

*******PLEASE ATTACH A COPY OF THE FRONT & BACK OF THE INSURANCE CARD(S)*******

*****If the injured party had additional private medical insurers since the date of injury that you have not listed in 1-5 above or in any previous sections of this questionnaire, please attach additional page(s) with information for any additional medical insurers the injured party had since the injury date AND provide a copy of the front and back of the insurance card(s) for those insurers.*****

V. PRE-SETTLEMENT FUNDING LOANS/ADVANCES

Did the injured party obtain <u>any</u> pre-settlement funding loans (loans from lenders such as Fast Trak, Cartiga, etc.)* or loans from his/her attorney*? YES ☐ NO ☐

If 'Yes', provide each lender name, lender contact phone number, account/contract number, loan amount, and current amount due, including interest, if known:

____

____

*by requesting this information, we are not ensuring or guaranteeing repayment of any loans. If settlement funds are available, we will pay these obligations from the injured party's settlement funds, net of attorney fees, case expenses and medical liens at a repayment rate per the terms of the loan agreement with the lender.

VI. BANKRUPTCY

Has the injured party ever declared Bankruptcy? YES ☐ NO ☐

If 'Yes', provide: Filing date(s): ________________ **<u>Discharge</u>** date(s): ________________

Is the bankruptcy case still active? **YES ☐ NO ☐**

<u>PLEASE READ</u>

Please make sure to provide complete and accurate information and <u>answer ALL questions</u> in this questionnaire. Failure to do so will result in a delay to final resolution of the injured party's case. Please note: unanswered questions cannot be considered as a 'No'. Answer all questions, even if they do not apply to the injured party. <u>You are responsible for providing complete and accurate information for any and all medical insurers that the injured party had since the date of injury</u>.

VII. RELEASE AND SIGNATURE

By signing below, you agree to the release of any of the information given above, including the injured party's name, address, social security number, and date of birth to the private and/or governmental agencies referenced in Parts III, IV, V and VI above. It is your responsibility to notify us if any of the benefit information changes or needs to be supplemented. You also understand that if you provide false, incorrect or inaccurate information or omit information, whether intentionally or unintentionally, the injured party will bear any and all financial responsibility arising from such misinformation. **The undersigned hereby swears under penalty of perjury that all of the information provided herein is true and accurate.**:

____ Date: _______/_______/_______

Injured Party Signature or Personal Representative Signature
if Injured Party is a minor, deceased or incapacitated

<u>If you are signing as a Personal Representative for the injured party, please complete the following:</u>

List your relationship to the Injured Party:____

Representative Name: ____
(First) (M.I.) (Last)

Current Mailing Address: ____

City: ______________________________ State: _______ Zip: ______________

Telephone: (_____)__________________ Email Address: ______________________________

<u>If you have signed this document as a Personal Representative, you must attach documents designating you as such (Power of Attorney, Letters Testamentary, Guardianship documentation, etc.)**</u>**

Exhibit E.2

HIPAA RELEASE FORM

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Claimant Name:________________________ Date:________________________

Date of Birth:__________________________ Soc. Sec. No.__________________

1. The following individuals or organizations are authorized to disclose my health records to the parties specified below in section #4:

   ____

   (Note: Please list the names of your medical care providers and your health insurance providers that may have records relevant to the resolution of your Personal Injury Claim. <u>If you are unsure of the exact legal name of your medical providers and health insurance providers, you can leave this blank, and we will complete it for you with the understanding that you authorize all relevant parties):</u>

2. The type and amount of information to be used or discloses is as follows:

   The entire record, including but not limited to: any and all medical records, problem lists, medication lists, lists of allergies, immunization records, history and physicals, discharge summaries, laboratory results, x-ray and imaging reports, medical images of any kind, video tapes, photographs, consultation reports, correspondence, itemized invoices and billing information, and information pertaining to Medicaid or Medicare eligibility and all payments made by those agencies, for the following dates:

   Dates of Services From:__________________ To: __________________

   (Note: List the date range for which the medical providers and insurance companies above may have records relevant to the resolution of your Personal Injury Claim. <u>If you are unsure of the exact dates, then leave this blank, and we will complete this section for you with the understanding that you authorize all relevant date ranges).</u>

3. I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus

(HIV). It may also include information about behavioral or mental health services, as well as treatment for alcohol and drug abuse.

4. The health information may be disclosed to and used by the following individual and/or organization:

GENTLE, TURNER & BENSON, LLC
501 Riverchase Parkway East, Suite 100
Hoover, Alabama 35244
(p) 205-716-3000 (f) 205-716-2364

5. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 5 years after the date that I sign it.

6. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and forego a recovery under Daily Harvest Settlement Class Action Settlement. I understand that no organization may condition treatment, payment, enrollment, or eligibility for benefits on my signing of this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 1634.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules or HIPAA. If I have questions about disclosure of my health information, I can contact the parties listed above in section #4.

________________________________ ____________________
Patient or Legal Representative Date

____
Relationship to Patient (If signed by Legal Representative)

Exhibit E.3

MEDICARE PROOF OF REPRESENTATION

Sign below if you, the Medicare beneficiary, want to inform the Centers for Medicare & Medicaid Services (CMS) that you have given another individual the authority to represent you and act on your behalf with respect to your claim for liability insurance, no-fault insurance, or workers' compensation, including releasing identifiable health information or resolving any potential recovery claim that Medicare may have if there is a settlement, judgment, award, or other payment. Your representative must also sign that he/she has agreed to represent you.

Type of Medicare Beneficiary Representative (Check one below and then print the requested information)**:**

( ) Individual other than an Attorney:
(X) Attorney*
( ) Guardian*
( ) Conservator*
( ) Power of Attorney*

Name: Edgar C. Gentle, III, Esq. and Katherine H. Benson, Esq.
Relationship to Medicare Beneficiary: Lien/Settlement Administrator
Firm or Company Name: Gentle, Turner & Benson, LLC
Address: 501 Riverchase Parkway East, Suite 100
Hoover, AL 35244
Telephone: (p) 205-716-3000 (f) 205-716-2364

Medicare Beneficiary Information and Signature/Date: **For this document, the injured party is the Beneficiary. Provide information for the inured party only. This does NOT mean a spouse or other heir/representative:**

Please complete numbers 1-4 below only:

1. Beneficiary's Name
   Please print exactly as shown on your Medicare card: ____________________

2. Beneficiary's Medicare Number (number on your Medicare card): ____________________

3. Date of Illness/Injury for which the beneficiary has filed a liability insurance, no-fault insurance or workers' compensation claim: ____________________
   (if you are unsure of the exact date of injury as listed on the complaint or demand, please leave this blank and we will complete it for you.)

4. Beneficiary Signature: ____________________ Date Signed: ____________

****Due to the recent nationwide change in the Medicare number system, please provide a copy of the front of your Medicare card. Failure to provide your current Medicare number could result in a delay in processing your case.****

For Lien Administrator's Use Only – DO NOT WRITE OR SIGN BELOW THIS LINE:

Representative Signature/Date:

Representative's Signature: ____________________ Date signed: ____________

Our File No.: ____________________