UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

FEDERAL TRADE COMMISSION, vs. SIMPLE HEALTH PLANS LLC, *et al.*	**No. 18-CV-62593-GAYLES**

OPT-IN FORM

Instructions: Please complete all sections of this form, then sign and date it. Return the completed form to the Receiver's office by March 15, 2025. You can send it via email to: **simplehealth@akerman.com**. **Additionally, you must include a copy of your valid state-issued driver's license**. Please note that if you do not follow these instructions, your request to Opt-In may not be accepted. For questions concerning this form, please contact the office of Michael I. Goldberg, Court-Appointed Receiver, at (954) 331-4198.

1. CONSUMER INFORMATION

Policyholder Name _____

Street Address _____

City / State / Zip Code / Country _____

Telephone Number: _____

Email: _____

DOB: _____ Membership ID: _____

2. CONSUMER'S ELECTION TO KEEP COVERAGE IN PLACE

THIS WILL CONFIRM THAT I HAVE REVIEWED THE RECEIVER'S IMPORTANT NOTICE CONCERNING MY RIGHT TO KEEP MY EXISTING HEALTHCARE PLAN(S) BEING SERVICED BY PREMIER HEALTH SOLUTIONS LLC ("PHS"). I UNDERSTAND THAT MY EXISTING HEALTHCARE PLAN(S) IS/ARE **NOT COMPREHENSIVE HEALTH INSURANCE.** THIS MEANS THAT IF I BECOME ILL OR REQUIRE HOSPITALIZATION**,** I WILL BE RESPONSIBLE FOR PAYING MOST OF THE MEDICAL BILLS OUT OF POCKET. DESPITE THIS, I WOULD LIKE TO KEEP THE FOLLOWING POLICY(IES) IN PLACE AND AUTHORIZE PHS TO CONTINUE TO DEDUCT MONTHLY PREMIUMS FROM MY ACCOUNT.

Policy Number (Member ID):_____; Product Name: _____

Policy Number (Member ID):_____; Product Name: _____

Policy Number (Member ID):_____; Product Name: _____

By signing your name below, you certify that you are the policyholder for the above-referenced healthcare plan(s) and that the information contained in this Opt-In Form is true and correct.

Policyholder Signature: _____

Policyholder Print Name: _____

Date: _____