Claims Department
PO Box 845
Stevens Point, WI 54481-0047
Toll Free: 1-800-295-4010

AIG Claims, Inc. is a wholly owned subsidiary of AIG and provides claims administration for the Group Policy provided with the Sanofi Promise Warranty Program.

Sanofi Promise Warranty Program for CABLIVI® (caplacizumab-yhdp)
HOSPITAL DECLARATIONS AND AUTHORIZATIONS FORM

(TO BE COMPLETED BY AN AUTHORIZED HOSPITAL REPRESENTATIVE)

PLEASE READ THE FOLLOWING AND SIGN WHERE REQUESTED AT THE BOTTOM OF PAGE THREE (3). FAILURE TO COMPLETE THIS FORM MAY DELAY THE PROCESSING OF YOUR CLAIM. Please complete all sections of this form.

CLAIM NO:

If you do not yet have a claim number, leave this section blank upon submission.

The information you provide will be used by Sanofi's third-party administrator, AIG Claims, Inc. and/or its affiliates (collectively, "AIG"), to determine eligibility, to administer warranty claims, to manage and improve the Program and to communicate with you about the Program.

By signing this form, I agree to the following: Completing the Warranty Claim Form, Physician Attestation Form, and the Hospital Declarations and Authorizations Form does not guarantee that the Hospital will qualify for the Program. AIG may contact the Hospital to administer the Program. AIG may verify the accuracy of the information I have provided and may ask for more information. Sanofi reserves the right to change or cancel the Program at any time. Should Sanofi change or cancel the program, it will continue to honor valid warranty claims related to qualifying doses of CABLIVI dispensed during the period in which the program was in effect. Any benefits provided under the Program are not contingent on any future purchase.

I certify and attest to the following (check all that apply):

	I am an authorized representative to file the claim on behalf of the Hospital.
	Hospital has purchased the product directly or through a Sanofi authorized distributor [ASD, Cardinal Specialty, McKesson Specialty or Biocare].
	Hospital has not requested reimbursement from any third party (e.g., insurance company, Medicaid, Medicare, patient, etc.) for the acquisition cost of CABLIVI treatment subject to the Warranty.
	Hospital (unless a Federal health care program beneficiary as defined in 42 CFR § 1000.10) will fully and accurately report the amount refunded to it as part of the Program in the applicable cost reporting mechanism or claim for payment filed with the Department of Health and Human Services or a state Medicaid agency. Furthermore, Hospital will provide, upon request by the Secretary of the Department of Health and Human Services or a state Medicaid agency, information provided to Hospital regarding the amount returned to you under the Program.
	This is the <u>only</u> warranty claim for this patient in the last 60 days per the Physician Attestation Form.
	CABLIVI was administered in accordance with FDA label and was discontinued by the treating physician for one of the qualifying non-responder reasons, per the Warranty Claim Form.

I declare that, to the best of my knowledge and belief, all of the information provided in support of this claim is complete, true and accurate. I understand that if I made or shall make any false or fraudulent statements or withhold material facts relating to this claim, this could result in Hospital disqualification of the benefits.

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I understand that information related to the claim may be disclosed to and used by AIG, for the purpose of processing the claim for benefits. I authorize disclosure of any and all information about the Sanofi Promise Warranty Program for CABLIVI in order to process the benefits including any insurance covering the program. I understand that the Sanofi Promise Warranty Program for CABLIVI information disclosed pursuant to this authorization may be used or disclosed to third parties, including AIG, to evaluate, process, or facilitate the claim for benefits including recovery of monies due from insurers, if any. For details about how AIG collects and uses personal information submitted via this form, please visit https://www.aig.com/privacy-policy.

Acknowledgement of State Fraud Laws

For residents of all states except those states and territories noted below:
WARNING: Any person who knowingly and with the intent to injure, defraud, deceive any insurance company or other person, who files a statement of claim containing any false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may be subject to criminal prosecution, civil penalties and forfeiture of insurance benefits.

For residents of WASHINGTON D.C., MAINE, TENNESSEE, VIRGINIA and WASHINGTON: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

For residents of ARKANSAS, KENTUCKY, LOUISIANA, NEW MEXICO, PENNSYLVANIA, RHODE ISLAND, TEXAS and WEST VIRGINIA:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under this title.

ARIZONA: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or Card Member for the purpose of defrauding or attempting to defraud the policyholder or Card Member with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE, IDAHO and OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

INDIANA: Any person who knowingly, and with intent to defraud an insurer, files a statement of claim containing false, incomplete or misleading information commits a felony.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment for a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Consent to Receive Electronic Communications

I agree to receive electronic communications from AIG to determine eligibility and administer warranty claims. I agree to be contacted by AIG for these purposes, including using an autodialer or prerecorded voice at the telephone number(s) provided. By requesting for AIG to communicate with me electronically, I consent to electronic delivery of notices, disclosures, documents and other communications from AIG via the communications method indicated in this form in relation to this claim, including leaving voicemails on the phone number indicated below. I agree to check my messages and/or email accounts and to inform AIG of any changes to the information below. I agree that all notices, disclosures and other communications that AIG provides to me electronically satisfies any legal requirements that such communications should be in writing. I understand that I can opt out of these communications at any time by contacting the AIG Claims Department at 1-800-295-4010.

Hospital Name: ____

Mailing Address (Street, City, State, Zip): ____

Hospital Representative Email: ____

Hospital Representative Fax (if applicable): ____

Hospital Representative Phone: _______________________________________

This correspondence is sent by AIG Claims, Inc. as authorized administrator for Sanofi and its insurer New Hampshire Insurance Company, an AIG Company.

SIGN HERE

Hospital Representative Signature: ____

Print Hospital Representative Name: ____

Hospital Representative Title: ____

Date: _______________________________________

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