CLASS ACTION CLAIM FORM

Diggs, et al., v. Mici, et al., 4:22 CV 40003 MRG

This Claim Form must be completed and sent so it is received by the Claims Administrator no later than September 4, 2025, for it to be considered.

DO NOT DELAY.

You must fill out all sections (Steps 1-5) for your claim to be considered.

Step 1: PERSONAL INFORMATION

Your Name: _____

Date of Birth: _____

DOC ID # _____

Street Address: _____

Town, State, Zip code: _____

Telephone number: _____

E-mail address: _____

Contact information of someone who will always know how to reach you *(family member/friend/guardian/personal representative contact)*:

Name/ relationship: _____

Street Address: _____

Town, State, Zip code:_____

Telephone number: _____

E-mail address: _____

Step 2: STATE WHY YOU BELIEVE YOU ARE A CLASS MEMBER

a. Check either box that applies to you *(or both boxes, if both apply)*.
b. If you check a box, explain what happened to you.
c. Provide any supporting documentation when you mail your Claim Form.
d. If neither box applies to you, you are not a Class Member and may not submit a Claim Form.

[CONTINUES ON BACK]

Questions? Write SBCC Settlement, c/o Analytics Consulting LLC,
PO Box 2006, Chanhassen MN 55317-2006;
Visit www.SBCCSettlement.com or call 866-910-8320

☐ I was part of the group from SBCC Unit N-1 who was forced to kneel for an extended period of time on January 10, 2020.

Provide your SBCC Unit N-1 cell number on January 10, 2020, and describe where and for how long you knelt. Send a copy of any supporting documentation.

_____

_____

_____

_____

(continue on a separate sheet of paper if needed)

☐ The Department of Correction staff used force on me during the period from January 10, 2020, to February 6, 2020.

Describe what happened, giving as many details as possible, such as date, time, location, type(s) of force and any weapon used, number of officers involved and names if known, any injuries you had, whether you received any medical attention (and if so, when and where), etc. **State whether you reported the incident to anyone** (whether to DOC or to someone on the outside), and if so, who you reported it to and when. If you did not report the incident to anyone, please state why not. **Send a copy of any supporting documentation you have.**

_____

_____

_____

_____

_____

(continue on a separate sheet of paper if needed)

Step 3. RACIAL/ETHNIC IDENTIFICATION

I identify as the following (check all that apply):

- ☐ Black/African American
- ☐ Hispanic/Latinx
- ☐ White
- ☐ Asian
- ☐ Native American/Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Other: _____

Step 4. SUBSTITUTE W-9 REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

You **must** have a valid Social Security Number or Taxpayer Identification Number in order to receive payment. Provide this in the boxes below:

☐☐☐ – ☐☐ – ☐☐☐☐

For most individuals, this is your Social Security Number.

Backup Withholding: Backup withholding is a type of federal tax withholding on specific types of income such as interest payments, dividends, commissions, royalties, and more. Most taxpayers are not subject to backup withholding. Backup withholding is NOT money owed to the Commonwealth of Massachusetts.

Under penalties of perjury, I certify (by my signature in Step 5, below) that (1) the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and (2) I am NOT subject to backup withholding

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because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and (3) that I am a U.S. person, defined as an individual who is a U.S. citizen or U.S. resident alien, or an estate.

If you have been notified by the IRS that you are subject to backup withholding, you must cross out the entire paragraph above. If you do not cross out the entire paragraph above, you will not be considered subject to backup withholding. If you are unsure whether or not this applies to you, contact the Internal Revenue Service.

Step 5. SIGN UNDER PAINS AND PENALTIES OF PERJURY THAT ALL INFORMATION IN THIS FORM IS CORRECT

I QUALIFY AS A CLASS MEMBER AND WISH TO MAKE A CLAIM.

By signing this form below, I certify that

1. I am the person identified above (in Step 1), or the guardian or personal representative of the person identified above;
2. The information I provide above about why I am Class Member (in Step 2) is true and accurate;
3. The information I provide about my racial/ethnic identity (in Step 3) is true and accurate;
4. The taxpayer information and certifications I provide above (in Step 4) are true and accurate. *The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding. These certifications appear above in Step 4;* and
5. I will accept, and be limited to, the formula for damages approved by the Court.
6. I am expressly authorizing DOC, the DOC's medical vendor, and the Commonwealth, to share necessary documentation and information to enable the processing of my claim as a Class Member, including, but not limited to, Criminal Offender Record Information (CORI) and medical/mental health information.

I declare under the pains and penalties of perjury that all of the information provided on this form is true and correct:

Date: _____ Signature: _____

If you are the guardian or personal representative of the Class Member named in this form, please indicate which, print, and sign your full name and provide a copy of the documentation of your legal appointment as guardian or personal representative.

☐ Guardian

☐ Personal Representative

_____ _____

Printed full name Signed full name

_____

Date

Step 6. MAIL THIS FORM SO THAT IT IS RECEIVED BY SEPTEMBER 4, 2025

Mail this form to the Claims Administrator at:

SBCC Settlement
c/o Analytics Consulting LLC
PO Box 2006
Chanhassen MN 55317-2006

NOTE: After you mail your claim form, you will receive a notice that your claim was approved or denied. If you do not receive the notice, you must contact the Claims Administrator at the address above, at SBCCSettlement@noticeadministrator.com or by phone at 866-910-8320. **If you move, you must notify the Claims Administrator in writing so that your check will be sent to your new address.** You must cash your check within one (1) year of the date the check was issued. All questions regarding this lawsuit or the settlement should be sent by mail to the Claims Administrator at the address above or by phone at 866-910-8320.