CLAIM FORM

Case No. 2026-013610-CA-01

Return this Claim Form to: CDS TCPA Settlement, PO Box 2009, Chanhassen, MN 55317-2009 OR CDSTCPASettlement@noticeadministrator.com. Questions, visit **www.CDSTCPASettlement.com** or call **866-969-1557.**

DEADLINE: THIS CLAIM FORM MUST BE SUBMITTED BY DECEMBER 24, 2026, BE FULLY COMPLETED, BE SIGNED, AND MEET ALL CONDITIONS OF THE SETTLEMENT AGREEMENT.

YOU MUST SUBMIT THIS CLAIM FORM TO RECEIVE A SETTLEMENT PAYMENT.

Please note that this Claim Form may be researched and verified by the Claim Administrator.

YOUR CONTACT INFORMATION

Name: _____
First Middle Last

Current Address: _____
City State ZIP Code

Telephone Number that you received a Text Message and/or Call from Coast Dental Services, LLC. at:

(_____) _____ – _____ **(Required)**

Email address *(if any)*: _____

Current Phone Number (Required): (_____) _____– _____ **or** ☐ check if same as above
(Please provide a phone number where you can be reached if further information is required.)

PLEASE CHECK ONE OF THE FOLLOWING BOXES TO SIGNIFY YOUR CHOICE (IF NONE IS CHECKED (or if the selection is unclear), YOU WILL RECEIVE A VOUCHER):

☐ **- I elect to receive up to $99.00 in a voucher which can be used to purchase an electronic toothbrush sold by Defendant.**

☐ **- I elect to receive up to $59.00 in cash payment**

SETTLEMENT CLASS MEMBER VERIFICATION

By submitting this claim form, I attest that to the best of my knowledge, that I received more than one text message and/or call from Coast Dental Services, LLC, reminding or encouraging the scheduling of an appointment after I made a request to Coast Dental Services, LLC to not receive future solicitations.

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Additional information regarding the Settlement can be found at www.CDSTCPASettlement.com.

Signature: _____ Date: _____

Print Name: _____

If you have questions, you may call the Claim Administrator at 866-969-1557.