SECTION II -- California Attorney General Settlement Claim Form

Section A: Claimant Identification

Please provide us with the following information related to the individual who **PAID** for Provigil®, Nuvigil®, and/or generic versions of Provigil® (modafinil) dispensed pursuant to a prescription for one or more of these drugs. This person is referred to as the "Claimant." If the person who **PAID** for the Provigil®, Nuvigil®, and/or generic versions of Provigil® is different than the person who was prescribed the drugs, then the Claimant is still the person who **PAID** for the drugs. So, for example, if a parent purchased Provigil® for their child, then the parent is the Claimant.

Claimant's Name

Agent/Legal Representative

Street Address

City	State	Zip Code

Daytime Telephone Number	E-Mail Address*

*By providing your e-mail address, you authorize the Settlement Administrator to use it in providing you with information relevant to this claim.

Section B: Eligible Claimants

You should file this Proof of Claim Form if, during the period from June 24, 2006 through December 31, 2012, you resided in California and purchased and/or paid for Provigil®, Nuvigil®, and/or generic versions of Provigil® (modafinil) dispensed pursuant to a prescription for personal consumption by you or for another under your caregiving in any state in the United States or the District of Columbia. Your purchases of these drugs are eligible regardless of the out-of-pocket costs you paid, even if you were partially or fully reimbursed by insurance. Employees of the defendants in *Vista Healthplan v. Cephalon* and *State of California v. Cephalon* are not eligible to submit a claim. The judge and his immediate family are not eligible to submit a claim.

	BY CHECKING THIS BOX, YOU ARE CONFIRMING THAT, DURING THE PERIOD FROM JUNE 24, 2006 THROUGH DECEMBER 31, 2012, YOU PURCHASED AND/OR PAID FOR PROVIGIL®, NUVIGIL®, AND/OR MODAFINIL IN ANY STATE IN THE UNITED STATES OR THE DISTRICT OF COLUMBIA AND YOU WERE A CALIFORNIA RESIDENT AT THE TIME OF EACH PURCHASE.

Section C: Purchase Information

Below, please write down the total number of prescriptions pursuant to which you purchased and/or paid for Provigil®, Nuvigil®, and/or generic versions of Provigil® (modafinil) during the period from June 24, 2006 to December 31, 2012 in any state in the United States or the District of Columbia. You must have been a California resident at the time you purchased and/or paid for Provigil®, Nuvigil®, and/or modafinil.

A Claimant "paid" for Provigil®, Nuvigil®, or generic versions of Provigil® (modafinil) if, for example, the Claimant had insurance and paid a co-payment or a co-insurance payment (that is, the Claimant's unreimbursed out-of-pocket cost) and insurance covered the rest. Also, an insured Claimant may have "paid" for the drug if she paid for the entire cost of the drug because the Claimant had not met a deductible. A Claimant not covered by insurance who purchased the drug would also be considered to have "paid" for the drug.

TOTAL NUMBER OF PRESCRIPTIONS FOR PROVIGIL®, NUVIGIL®, AND/OR MODAFINIL FROM JUNE 24, 2006 THROUGH DECEMBER 31, 2012 PURSUANT TO WHICH YOU PURCHASED ANY OF THESE DRUGS:	

Section D: Releases

The Settlement Agreement between the Attorney General of the State of California and Teva Pharmaceutical Industries Ltd. describes in detail what claims you are releasing in this case (whether or not you file a Proof of Claim, unless you have excluded yourself). If you would like to review the Releases, they are available at www.ProvigilSettlement.com/CA.

Section E: Sworn Statement

By signing this Claim Form, I declare under penalty of perjury that: (1) all of the information provided in this Claim Form is true and correct to the best of my knowledge; (2) the Claimant is an Eligible Claimant as described in Section B above; (3) the Claimant purchased Provigil®, Nuvigil®, and/or modafinil pursuant to the number of prescriptions stated in Section C above at some time during the period from June 24, 2006 through December 31, 2012; and (4) if not submitting this for myself, I am authorized to submit this form on behalf of the Claimant identified above.

Please note that signing a Claim Form that contains false information could constitute perjury.

Signature	Print or Type Name

Date

You must mail the completed Claim Form so that it is received on or before , by the Settlement Administrator at the following address (even if you are submitting claims for both Settlements):

Provigil Settlement
c/o A.B. Data, Ltd.
P.O. Box 170300
Milwaukee, WI 53217
Toll-Free Telephone: 1-877-241-7503 Email: info@ProvigilSettlement.com
Website: www.ProvigilSettlement.com/CA

REMINDER CHECKLIST:

1. Please complete and sign the above Claim Form.
2. Keep a copy of your Claim Form for your records.
3. If you would also like acknowledgement of receipt of your Claim Form, please complete the form online or mail this form via Certified Mail, Return Receipt Requested.
4. If you move and/or your name changes, please send your new address and/or your new name or contact information to the Settlement Administrator via the Settlement Website or U.S. Mail (the addresses are listed above).