ELITE INTEGRATED MEDICAL, LLC CLAIM FORM

Georgia Department of Law – Consumer Protection Division

Review this form before filling it out. Please type or print legibly in black or blue ink.

- This Claim Form is for consumers who purchased a regenerative medicine product from *Elite Integrated Medical, LLC in the State of Georgia*, and have *not* received a previous refund, restitution payment, or settlement for this claim. The regenerative medicine product purchased must be a product that is the subject of the State's FBPA claims.
- Fill out the form *completely.* Failure to provide all of the information requested will not necessarily result in the denial of your claim; it could, however, delay consideration of your claim while we request additional information from you, or it could impact your ability to demonstrate your loss and/or recover restitution. Questions should be directed to Investigator Bae by email only to dbae@law.ga.gov.
- **Documents Requested.** Return this Claim form with copies (*no originals please*) of:

  1. Documents showing that the regenerative medicine product(s) was purchased from, and provided by, Elite in the State of Georgia;
  2. Documents that reflect the product(s) purchased from Elite; the original payment(s) made to Elite Integrated Medical, LLC; and the amount of those payment(s), such as a copy of a check, receipt of an invoice, etc…; and
  3. Any communication to or from Elite or its agents regarding complaints, inquiries, questions, or requests for refunds that you may have made. If this communication was primarily in-person or by telephone, please provide, wherever possible, records reflecting your communication with the business, as well as names of personnel with whom you spoke.

  In some cases, the Georgia Department of Law, Consumer Protection Division may need to request additional documentation from you.
- Fill out each section of this form. Keep a copy of both pages and any attachments for your records. Provide any address changes in writing if it changes before the end of the claim period.
- Submit your completed Claim Form and any documentation by mail, overnight delivery, or fax. ***You may not submit the Claim Form by email.***

Mail completed Claim Form and accompanying documents to:

Elite Integrated Medical Restitution Program
Georgia Department of Law, Consumer Protection Division
2 Martin Luther King Jr. Drive, Suite 356
Atlanta, GA 30334-9077

Fax Claim Forms (including documentation) should be faxed to 404-651-9018

Your submission must be postmarked on or by the 1st of August, 2023.

- Please be aware that restitution will be drawn from funds held in a Restitution Fund. If the total amount claimed by consumers exceed the amount in the Restitution Fund, the funds will be distributed pro rata. This means that while you may be eligible for restitution, you may not receive the full amount requested.
- You will receive a response confirming or denying your eligibility from CPD no later than September 29, 2023. While we will distribute funds from the Restitution Fund to eligible consumers as quickly as possible, please note it is a time-consuming process to evaluate and verify each claim submitted. Your patience is appreciated.

CLAIM FORM

Consumer Name: _____
First *Middle Initial* *Last*

Last Four Digits of Consumer's Social Security Number (**Required**): ___ ___ ___ ___

Mailing Address (**Required**):_____

City: _____ State_____ Zip_____

Phone: (___) _____(Day) (___) _____ (Night) (___) _____ Email: _____

Have you ever filed a complaint about Elite Integrated Medical, LLC with the Company, the Consumer Protection Division, the Better Business Bureau, or any other State or Federal regulatory agency? Yes ☐ No ☐

If Yes: list the company or agency name, representative or agent with contact info., and file number (if known)

_____

Do you have a copy of the original complaint submitted? Yes ☐ No ☐

Product/Service Purchased: _____

Date of Purchase: ___/___/____ Purchase Price: _____

Amount you claim you are owed as refund or reimbursement: $_____

Have you received a refund, account credit, replacement or other payment from Elite Integrated Medical, LLC, your credit card company, or from any other source related to the product or service you have identified on this claim form? Yes ☐ No ☐

Have you been or are you currently a party to any legal action against Elite Integrated Medical, LLC? Yes ☐ No ☐

If you answered "YES" to either question, please explain and identify any amounts you were refunded:

_____

_____

Please provide a brief explanation of your claim below and how you determined the monetary amount you are claiming. Your claim eligibility as well as your claim amount will be subject to verification and a representative of our office may need to contact you to ask for clarifying information.

_____

_____

_____

_____

Have you attached documents to substantiate your claim amount? Yes ☐ No ☐

I declare, under penalty of perjury under the laws of the State of Georgia, that the information contained in this claim is true and accurate, and that any documents attached are true and accurate copies of the originals. I understand that my claim and the related documents will become a "public record" under state law, and thus can be subject to a public records disclosure request and/or be seen by other people.

_____ ___/___/____ _____

Signature Date City and State where signed

The Claim Form must be returned postmarked no later than the 1st of August, 2023.
You may not submit this form by email.