

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
SOUTHERN DIVISION**

WANDA WOMACK, et al.,)
)
Plaintiffs,)
vs.)
)
)
)
DOLGENCORP., INC.; d/b/a)
DOLLAR GENERAL, et al.,)
)
Defendants.)

**LEAD CASE NUMBER:
2:06-cv-0465-VEH-RRA**

TINA M. WOOD, et al.)
)
Plaintiffs,)
)
)
)
DOLGENCORP., INC.; d/b/a)
DOLLAR GENERAL, et al.,)
)
Defendants.)

**MEMBER CASE NUMBER:
2:08-cv-1602-VEH-RRA**

**CLAIMS FORM TO SEEK
AN ADDITIONAL AWARD FROM THE SETTLEMENT FUND**

AS EXPLAINED FULLY IN THE CLASS ACTION SETTLEMENT NOTICE SENT TO YOU ON MAY 29, 2012, SETTLEMENT CLASS MEMBERS WHO HAVE NOT OPTED OUT OF THE SETTLEMENT CLASS MAY BE ELIGIBLE TO RECEIVE A BASE AWARD AND AN ADDITIONAL AWARD (“CLAIMS AWARD”) FROM THE SETTLEMENT FUND. YOU MAY BE ELIGIBLE FOR A CLAIMS AWARD BASED ON THE INFORMATION YOU PROVIDE IN THIS CLAIMS FORM. YOU MUST COMPLETE THIS CLAIMS FORM TO BE CONSIDERED FOR AN ADDITIONAL AWARD.

Please complete your accurate and complete address information below.

Full Name: _____
First/Middle Initial/Last Name

Address: _____
Street Address, including any apartment or box number

City, State, Zip Code

CLAIM FORM INSTRUCTIONS

All information contained in this Claim Form will be kept strictly confidential. You are required to maintain the confidentiality of this Claim Form and may not disclose it to anyone except that you may consult legal counsel or tax advisors. You will not be subject to retaliation simply because you answered these questions.

Your answers to Sections A and D are required for you to participate in the claims process for an additional award ("Claims Award") from the Settlement Fund in this case. You may answer Sections B and/or C to the extent that they apply to you. Fill in only what applies to you. The monetary award that you receive will be determined based on your answers to these questions by the independent Claims Administrator pursuant to instructions provided as part of the Settlement Agreement approved by the Court.

You must sign and date your Claim Form under penalty of perjury.

You may use additional sheets of paper to answer any question on the Claim Form. If you do so, please be sure to put your name, social security number, and the question number on each additional sheet of paper you include with your Claim Form.

Please keep a copy of your Claim Form and any documents you submit with it. The Claims Administrator cannot return any claim forms or other documents to claimants.

IN ORDER TO BE ELIGIBLE TO RECEIVE A CLAIMS AWARD, YOU MUST RETURN THIS CLAIM FORM POSTMARKED ON OR BEFORE JUNE 22, 2012 TO:

Womack v. Dollar General Claims Administrator
P.O. Box 1813
Tallahassee, FL 32302-1813
(877) 236-6515

SECTION A
REQUIRED BACKGROUND INFORMATION

You must complete Questions Nos. 1 through 8 in order for your Claim Form to be processed.

- | | |
|---|---|
| 1. _____
Home Telephone | 2. _____
Work/Daytime Telephone |
| 3. _____
Cell Phone (if any) | 4. _____
Personal Email Address (if any) |
| 5. _____
Social Security Number
<i>[CLAIM FORMS THAT LACK SOCIAL SECURITY NUMBERS CANNOT BE PROCESSED]</i> | 6. _____
Date of Birth (Month/Day/Year) |
| 7. Please list any previous names you have used, including any used while you were employed by Dollar General:

_____ | |
| 8. Are you female? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

SECTION B

FACTS YOU BELIEVE SUPPORT YOUR INDIVIDUAL CLAIMS OF GENDER-BASED PAY DISCRIMINATION

If you do not believe that you have facts in support of an individual claim of gender-based pay discrimination by Dollar General please skip this section.

9. Do you believe that you have any specific facts in support of a claim of gender-based pay discrimination as a Store Manager at Dollar General?

Yes No

- a. If “Yes,” please explain any facts that you believe support your claim(s) of gender-based pay discrimination (use additional sheets if necessary):

SECTION C

MEDICAL AND/OR PSYCHOLOGICAL EFFECTS OF DISCRIMINATION

IF YOU BELIEVE YOU EXPERIENCED MEDICAL AND/OR PSYCHOLOGICAL EFFECTS OF GENDER PAY DISCRIMINATION, PLEASE ANSWER QUESTIONS 10-11. PLEASE NOTE THAT YOU DO NOT NECESSARILY HAVE TO HAD SOUGHT HEALTH CARE TREATMENT TO BE ELIGIBLE FOR AN CLAIMS AWARD

10. Do you believe in good faith that any of the gender-based discrimination you have been subjected to resulted in emotional, mental or physical injury to you?

Yes No

If “No,” skip question 11.

11. If “Yes,” please check each type of health care treatment you sought as a result of the emotional, mental or physical injury you contend you experienced as a result of gender-based pay discrimination at Dollar General:

- Medical doctor
 Social worker
 Psychiatrist
 Psychologist

- Chiropractor
- Therapist
- Priest, Pastor or other Clergy
- Other mental health professional (describe): _____
- None of the above

DO NOT SEND MEDICAL RECORDS TO THE CLAIMS ADMINISTRATOR WITH YOUR CLAIM FORM. THEY CANNOT BE REVIEWED AND WILL NOT BE RETURNED TO YOU.

SECTION D
SWORN AFFIRMATION AND SIGNATURE

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION AND FACTS I HAVE STATED IN THIS CLAIM FORM ARE TRUE AND ACCURATE TO THE BEST OF MY PERSONAL KNOWLEDGE. I UNDERSTAND THAT MAKING A KNOWINGLY FALSE STATEMENT MAY SUBJECT ME TO PROSECUTION FOR PERJURY.

I UNDERSTAND AND AGREE THAT, BASED ON MY RECEIPT OF THE BASE AWARD IN THIS ACTION AND ANY OTHER AWARD I MAY RECEIVE AS A RESULT OF THIS CLASS ACTION SETTLEMENT, THAT I HAVE RELEASED DOLLAR GENERAL FROM THE CLAIMS DESCRIBED IN THE SETTLEMENT AGREEMENT AND NOTICE, INCLUDING ANY CLAIMS OF GENDER-BASED PAY DISCRIMINATION UNDER TITLE VII OF THE CIVIL RIGHTS ACT OF 1964 AND THE EQUAL PAY ACT.

I understand that I must keep the Claims Administrator informed of my current address and of any change in my home address. If I do not do so, I understand that I may not receive any award that I might otherwise be entitled to receive.

Executed this ____ day of _____, 2012

 Signature of Claimant*

 Typed or Printed Name of Claimant

 Social Security Number of Claimant

***UNSIGNED CLAIM FORMS WILL NOT BE PROCESSED.**

WHEN YOU HAVE COMPLETED THIS CLAIM FORM, PUT IT IN AN ENVELOPE, PUT POSTAGE ON IT, AND MAIL IT SO THAT IT IS POSTMARKED BY NO LATER THAN JUNE 22, 2012 TO:

Womack v. Dollar General Claims Administrator
P.O. Box 1813
Tallahassee, FL 32302-1813
(877) 236-6515

PLEASE RETAIN A COPY OF YOUR COMPLETED CLAIM FORM AND ANY ATTACHMENTS. NO CLAIM FORMS OR ATTACHMENTS WILL BE RETURNED TO CLAIMANTS.