Waiver of Objection to Payment of Fees

Instructions: Health Plan will only pay Claimant's share of the Neutral Arbitrator's fees and expenses if this form is completed and returned to the Independent Administrator and a copy served on Respondents. **All Claimants and their counsel must sign this form**. If Claimants seek damages of more than $200,000, they must also sign and return the Waiver of Party Arbitrator Form to be entitled to Health Plan's payment of the Neutral Arbitrator's fees. See Arbitration Rule 15.a. Return this form to

Office of the Independent Administrator
3580 Wilshire Boulevard, Suite 2020
Los Angeles, California 90010
Fax: 213-637-8658

Name of Arbitration _____ Arbitration number _____

Normally, the fees and expenses of a Neutral Arbitrator are divided between the Claimants and Respondents. I/We, the Claimant(s) in the arbitration listed above, agree that I/we will waive any or all claims, present or future, I/we may have based on Kaiser Foundation Health Plan' payment of the fees and expenses incurred by the Neutral Arbitrator. In exchange for waiving any such claims and waiving any right to a Party Arbitrator, Kaiser Foundation Health Plan will pay the fees and expenses incurred by the Neutral Arbitrator.

I/We make this decision voluntarily and after the opportunity to discuss the decision with counsel.

_____ _____
Signature of Claimant Date

_____ _____
Signature of Claimant Date

_____ _____
Signature of Claimant Date

_____ _____
Signature of Claimant's Counsel Date

To be effective, all of the Claimants and Counsel must sign this Form.