

Healthcare Services Group, Inc. Securities Litigation
c/o A.B. Data, Ltd.
P.O. Box 173002
Milwaukee, WI 53217
Toll-Free Number: 1-877-777-9675
Settlement Website: www.HCSGSecuritiesLitigation.com
Email: info@HCSGSecuritiesLitigation.com

PROOF OF CLAIM AND RELEASE FORM

To be eligible to receive a share of the Net Settlement Fund in connection with the Settlement of *Utah Retirement Systems, et al. v. Healthcare Services Group, Inc., et al.*, No. 2:19-cv-01227-ER (E.D. Pa.) (the “Action”), pending in the United States District Court for the Eastern District of Pennsylvania (the “Court”), you must be a Settlement Class Member and complete and sign this Proof of Claim and Release Form (“Claim Form”) and (i) mail it by First-Class Mail to the above address **postmarked (or received) no later than February 7, 2022** or (ii) submit online at www.HCSGSecuritiesLitigation.com **by no later than February 7, 2022**.

Failure to submit your Claim Form by the date specified will subject your Claim to rejection and may preclude you from being eligible to recover any money in connection with the Settlement.

Do not mail or deliver your Claim Form to the Court, the Settling Parties, or their counsel. Submit your Claim Form only to the Claims Administrator at the address set forth above.

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PART I – CLAIMANT INFORMATION

(Please read Part II - General Instructions below before completing this page.)

The Claims Administrator will use this information for all communications regarding this Claim Form. If this information changes, you MUST notify the Claims Administrator in writing at the address above.

Beneficial Owner's Name

Co-Beneficial Owner's Name

Entity Name (if Beneficial Owner is not an individual)

Representative or Custodian Name (if different from Beneficial Owner(s) listed above)

Address 1 (street name and number)

Address 2 (apartment, unit, or box number)

City

State

Zip Code

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Foreign Country (only if not USA)

Last four digits of Social Security Number or Taxpayer Identification Number

Telephone Number (day)

Telephone Number (evening)

<input type="text"/>	<input type="text"/>
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Email address (Email address is not required, but if you provide it you authorize the Claims Administrator to use it in providing you with information relevant to this Claim.)

Account Number (account(s) through which the securities were traded)¹

Claimant Account Type (check appropriate box):

- Individual (includes joint owner accounts) Pension Plan Trust
 Corporation Estate
 IRA/401K Other _____ (please specify)

¹ If the account number is unknown, you may leave blank. If filing for more than one account for the same legal entity, you may write "multiple." Please see paragraph 11 of the General Instructions for more information on when to file separate Claim Forms for multiple accounts, *i.e.*, when you are filing on behalf of distinct legal entities.

PART II – GENERAL INSTRUCTIONS

1. It is important that you completely read and understand the Notice of Pendency of Class Action and Proposed Settlement, Final Approval Hearing, and Motion for Attorneys' Fees and Reimbursement of Litigation Expenses (the "Notice") that accompanies this Claim Form, including the Plan of Allocation set forth in the Notice. The Notice describes the proposed Settlement, how Settlement Class Members are affected by the Settlement, and the manner in which the Net Settlement Fund will be distributed if the Settlement and Plan of Allocation are approved by the Court. The Notice also contains the definitions of many of the defined terms (which are indicated by initial capital letters) used in this Claim Form. By signing and submitting this Claim Form, you will be certifying that you have read and that you understand the Notice, including the terms of the releases described therein and provided for herein.

2. This Claim Form is directed to all Persons who purchased or otherwise acquired Healthcare Services Group common stock (Ticker: HCSG) (CUSIP: 421906108) during the period between April 8, 2014 through February 9, 2021, inclusive, and were allegedly damaged thereby ("Settlement Class"). Any Person who falls within the definition of the Settlement Class is referred to as a "Settlement Class Member."

3. Excluded from the Settlement Class are: (i) Defendants and any affiliates or subsidiaries of HCSG; (ii) present or former officers, directors, or controlling persons of HCSG, its subsidiaries, or its affiliates, and their immediate family members; (iii) Defendants' directors' and officers' liability carriers and any affiliates or subsidiaries thereof; (iv) any entity in which any Defendant has or has had a controlling interest; and (v) the legal representatives, heirs, estates, agents, successors, or assigns of any person or entity described in the preceding categories. Also excluded from the Settlement Class are any Persons who otherwise satisfy the above requirements for membership in the Settlement Class, but who exclude themselves by submitting a valid request for exclusion in accordance with the requirements set forth in the Notice.

4. If you are not a Settlement Class Member, do not submit a Claim Form. **YOU MAY NOT, DIRECTLY OR INDIRECTLY, PARTICIPATE IN THE SETTLEMENT IF YOU ARE NOT A SETTLEMENT CLASS MEMBER. THUS, IF YOU ARE EXCLUDED FROM THE CLASS (AS SET FORTH IN PARAGRAPH 3 ABOVE), ANY CLAIM FORM THAT YOU SUBMIT, OR THAT MAY BE SUBMITTED ON YOUR BEHALF, WILL NOT BE ACCEPTED.**

5. If you are a Settlement Class Member, you will be bound by the terms of any judgments or orders entered in the Action **WHETHER OR NOT YOU SUBMIT A CLAIM FORM**, unless you submit a request for exclusion from the Class. Thus, if you are a Settlement Class Member, the Judgment will release, and enjoin the filing or continued prosecution of, the Released Plaintiffs' Claims against the Defendants and Defendants' Releasees.

6. You are eligible to participate in the distribution of the Net Settlement Fund only if you are a member of the Class and if you complete and return this Claim Form as specified herein. If you fail to submit a timely, properly addressed, and completed Claim Form with the required documentation, your Claim may be rejected, and you may be precluded from receiving any distribution from the Net Settlement Fund.

7. Submission of this Claim Form does not guarantee that you will share in the proceeds of the Settlement. The distribution of the Net Settlement Fund will be governed by the Plan of Allocation set forth in the Notice, if it is approved by the Court, or by such other plan of allocation approved by the Court.

8. Use the Schedule of Transactions in Part III of this Claim Form to supply all required details of your transaction(s) in and holdings of Healthcare Services Group common stock. On the Schedule of Transactions, please provide all of the requested information with respect to your holdings, purchases, acquisitions, and sales of Healthcare Services Group common stock, whether such transactions resulted in a profit or a loss. Failure to report all transaction and holding information during the requested time periods may result in the rejection of your Claim.

9. Please note: To be eligible to receive a distribution under the Plan of Allocation, you must have purchased or otherwise acquired Healthcare Services Group common stock between April 8, 2014 through February 9, 2021, inclusive.

10. You are required to submit genuine and sufficient documentation for all of your transactions and holdings of Healthcare Services Group common stock set forth in the Schedule of Transactions in Part III of this Claim Form. Documentation may consist of copies of brokerage confirmation slips or monthly brokerage account statements, or an authorized statement from your broker containing the transactional and holding information found in a broker confirmation slip or account statement. The Parties and the Claims Administrator do not independently have information about your investments in Healthcare Services Group common stock. **IF SUCH DOCUMENTS ARE NOT IN YOUR POSSESSION, PLEASE OBTAIN COPIES OR EQUIVALENT CONTEMPORANEOUS DOCUMENTS FROM YOUR BROKER. FAILURE TO SUPPLY THIS DOCUMENTATION MAY RESULT IN THE REJECTION OF YOUR CLAIM. DO NOT SEND ORIGINAL DOCUMENTS. Please keep a copy of all documents that you send to the Claims Administrator. Also, please do not highlight any portion of the Claim Form or any supporting documents.**

11. **One Claim Form should be submitted for each separate legal entity or separately managed account.** Separate Claim Forms should be submitted for each separate legal entity (e.g., an individual should not combine his or her IRA holdings and transactions with holdings and transactions made solely in the individual's name). Generally, a single Claim Form should be submitted on behalf of one legal entity including all holdings and transactions made by that entity on one Claim Form. However, if a single person or legal entity had multiple accounts that were separately managed, separate Claim Forms may be submitted for each such account.

The Claims Administrator reserves the right to request information on all the holdings and transactions in Healthcare Services Group common stock made on behalf of a single beneficial owner.

12. All joint beneficial owners must sign this Claim Form. If you purchased or otherwise acquired Healthcare Services Group common stock and held the securities in your name, you are the beneficial owner as well as the record owner and you must sign this Claim Form to participate in the Settlement. If, however, you purchased or otherwise acquired Healthcare Services Group common stock and the securities were registered in the name of a third party, such as a nominee or brokerage firm, you are the beneficial owner of these securities, but the third party is the record owner. The beneficial owner, not the record owner, must sign this Claim Form.

13. Agents, executors, administrators, guardians, and trustees must complete and sign the Claim Form on behalf of persons represented by them, and they must:

- (a) expressly state the capacity in which they are acting;
- (b) identify the name, account number, Social Security Number (or Taxpayer Identification Number), address, and telephone number of the beneficial owner of (or other person or entity on whose behalf they are acting with respect to) the Healthcare Services Group common stock; and
- (c) furnish herewith evidence of their authority to bind to the Claim Form the person or entity on whose behalf they are acting. (Authority to complete and sign a Claim Form cannot be established by stockbrokers demonstrating only that they have discretionary authority to trade stock in another person's accounts.)

14. By submitting a signed Claim Form, you will be swearing that you:

- (a) own(ed) the Healthcare Services Group common stock you have listed in the Claim Form; or
- (b) are expressly authorized to act on behalf of the owner thereof.

15. By submitting a signed Claim Form, you will be swearing to the truth of the statements contained therein and the genuineness of the documents attached thereto, subject to penalties of perjury under the laws of the United States of America. The making of false statements, or the submission of forged or fraudulent documentation, will result in the rejection of your Claim and may subject you to civil liability or criminal prosecution.

16. If the Court approves the Settlement, payments to eligible Authorized Claimants pursuant to the Plan of Allocation (or such other plan of allocation as the Court approves) will be made after the completion of all Claims processing. This could take substantial time. Please be patient.

17. PLEASE NOTE: As set forth in the Plan of Allocation, each Authorized Claimant shall receive his, her, or its *pro rata* share of the Net Settlement Fund. If the prorated payment to any Authorized Claimant, however, calculates to less than \$10.00, it will not be included in the calculation and no distribution will be made to that Authorized Claimant.

18. If you have questions concerning the Claim Form, or need additional copies of the Claim Form or the Notice, you may contact the Claims Administrator, A.B. Data, Ltd., by email at info@HCSGSecuritiesLitigation.com, or by toll-free phone at 1-877-777-9675, or you may download the documents from the Settlement website, www.HCSGSecuritiesLitigation.com.

19. NOTICE REGARDING ELECTRONIC FILES: Certain Claimants with large numbers of transactions may request, or may be requested, to submit information regarding their transactions in electronic files. To obtain the mandatory electronic filing requirements and file layout, you may visit the Settlement website at www.HCSGSecuritiesLitigation.com, or you may email the Claims Administrator's electronic filing department at info@HCSGSecuritiesLitigation.com. Any file not in accordance with the required electronic filing format will be subject to rejection. No electronic files will be considered to have been properly submitted unless the Claims Administrator issues an email to that effect after processing your file with your Claim numbers and respective account information. Do not assume that your file has been received or processed until you receive this email. If you do not receive such an email within 10 days of your submission, you should contact the electronic filing department at info@HCSGSecuritiesLitigation.com to inquire about your file and confirm it was received and acceptable.

IMPORTANT: PLEASE NOTE

YOUR CLAIM IS NOT DEEMED FILED UNTIL YOU RECEIVE AN ACKNOWLEDGEMENT POSTCARD OR ONLINE RECEIPT. THE CLAIMS ADMINISTRATOR WILL ACKNOWLEDGE RECEIPT OF YOUR CLAIM FORM BY MAIL WITHIN 60 DAYS OR BY GENERATING A RECEIPT PROMPTLY FOLLOWING YOUR ONLINE SUBMISSION. IF YOU DO NOT RECEIVE AN ACKNOWLEDGEMENT POSTCARD WITHIN 60 DAYS, PLEASE CALL THE CLAIMS ADMINISTRATOR TOLL-FREE AT 1-877-777-9675.

PART III – SCHEDULE OF TRANSACTIONS IN HEALTHCARE SERVICES GROUP COMMON STOCK

Complete this Part III if, and only if, you purchased or otherwise acquired Healthcare Services Group common stock during the period April 8, 2014 through February 9, 2021, inclusive. Please include proper documentation with your Claim Form as described in detail in Part II – General Instructions, Paragraph 10, above. Do not include information in this section regarding securities other than Healthcare Services Group common stock (Ticker: HCSG) (CUSIP: 421906108).

1. HOLDINGS AS OF APRIL 7, 2014 – State the total number of shares of Healthcare Services Group common stock (Ticker: HCSG) currently held as of the close of trading on April 7, 2014. (Must be documented.) If none, write “zero” or “0.”

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2. PURCHASES/ACQUISITIONS FROM APRIL 8, 2014 THROUGH FEBRUARY 9, 2021 – Separately list each and every purchase/acquisition of Healthcare Services Group common stock (Ticker: HCSG) made from after the opening of trading on April 8, 2014, through and including the close of trading on February 9, 2021. (Must be documented.)

Date of Purchase/ Acquisition (List Chronologically) (Month/Day/Year)	Number of Shares Purchased/ Acquired	Purchase/Acquisition Price Per Share	Total Purchase/Acquisition Price (excluding taxes, commissions, and fees)
/ /		\$	\$
/ /		\$	\$
/ /		\$	\$
/ /		\$	\$

3. PURCHASES/ACQUISITIONS FROM FEBRUARY 10, 2021, THROUGH MAY 10, 2021. – State the total number of shares of Healthcare Services Group common stock (Ticker: HCSG) purchased/acquired from after the opening of trading on February 10, 2021, through and including the close of trading on May 10, 2021. If none, write “zero” or “0.”

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4. SALES OF HEALTHCARE SERVICE GROUP COMMON STOCK FROM APRIL 8, 2014 THROUGH MAY 10, 2021 – Separately list each and every sale/disposition of Healthcare Services Group common stock (Ticker: HCSG) that were purchased or otherwise acquired from after the opening of trading on April 8, 2014, through and including the close of trading on May 10, 2021. (Must be documented.)

**IF NONE,
CHECK HERE**

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Date of Sale (List Chronologically) (Month/Day/Year)	Number of Shares Sold	Sale Price Per Share	Total Sale Price (excluding taxes, commissions, and fees)
/ /		\$	\$
/ /		\$	\$
/ /		\$	\$
/ /		\$	\$

5. HOLDINGS AS OF MAY 10, 2021 – State the total number of shares of Healthcare Services Group common stock (Ticker: HCSG) currently held as of the close of trading on May 10, 2021. (Must be documented.) If none, write “zero” or “0.”

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**IF YOU NEED ADDITIONAL SPACE TO LIST YOUR TRANSACTIONS, YOU MUST
PHOTOCOPY THIS PAGE AND CHECK THIS BOX.
IF YOU DO NOT CHECK THIS BOX THESE ADDITIONAL PAGES WILL NOT BE REVIEWED.**

PART IV – RELEASE OF CLAIMS AND SIGNATURE

YOU MUST ALSO READ THE RELEASE AND CERTIFICATION BELOW AND SIGN ON PAGE 7 OF THIS CLAIM FORM.

I (we) hereby acknowledge that, as of the Effective Date of the Settlement, pursuant to the terms set forth in the Stipulation, I (we), on behalf of myself (ourselves) and my (our) heirs, executors, administrators, predecessors, successors, affiliates, and assigns, in their capacities as such, shall be deemed to have, and by operation of law and of the Judgment shall have, fully, finally, and forever released, relinquished, and discharged all Plaintiffs' Released Claims (as defined in the Stipulation and in the Notice) against Defendants and Defendants' Releasees (as defined in the Stipulation and in the Notice), whether served or unserved with any complaint in the Action, and shall have covenanted not to sue Defendants or Defendants' Releasees with respect to all such Released Plaintiffs' Claims, and shall be permanently barred and enjoined from asserting, commencing, prosecuting, instituting, assisting, instigating, or in any way participating in the commencement or prosecution of any action or other proceeding, in any forum, asserting any Released Plaintiffs' Claims, either directly, representatively, or in any other capacity, against any of Defendants or Defendants' Releasees.

CERTIFICATION

By signing and submitting this Claim Form, the Claimant(s) or the person(s) who represent(s) the Claimant(s) certifies (certify), as follows:

1. that I (we) have read and understand the contents of the Notice and this Claim Form, including the releases provided for in the Settlement and the terms of the Plan of Allocation;
2. that the Claimant(s) is a (are) Settlement Class Member(s), as defined in the Notice and in paragraph 2 on page 3 of this Claim Form, and is (are) not excluded from the Settlement Class by definition or pursuant to request as set forth in the Notice and in paragraph 3 on page 3 of this Claim Form;
3. that I (we) own(ed) the Healthcare Services Group common stock and have not assigned the claim against the Defendants' Releasees to another or that, in signing and submitting this Claim Form, I (we) have the authority to act on behalf of the owner(s) thereof;
4. that the Claimant(s) has (have) not submitted any other Claim covering the same purchases/acquisitions of Healthcare Services Group common stock and knows (know) of no other person having done so on the Claimant's (Claimants') behalf;
5. that the Claimant(s) submit(s) to the jurisdiction of the Court with respect to Claimant's (Claimants') Claim and for purposes of enforcing the releases set forth herein;
6. that I (we) agree to furnish such additional information with respect to this Claim Form as Lead Counsel, the Claims Administrator, or the Court may require;
7. that the Claimant(s) waive(s) the right to trial by jury, to the extent it exists, and agree(s) to the Court's summary disposition of the determination of the validity or amount of the Claim made by this Claim Form;
8. that I (we) acknowledge that the Claimant(s) will be bound by and subject to the terms of any judgment(s) that may be entered in the Action; and
9. that the Claimant(s) is (are) NOT subject to backup withholding under the provisions of Section 3406(a)(1)(C) of the Internal Revenue Code because (a) the Claimant(s) is (are) exempt from backup withholding or (b) the Claimant(s) has (have) not been notified by the IRS that he/she/it is subject to backup withholding as a result of a failure to report all interest or dividends or (c) the IRS has notified the Claimant(s) that he/she/it is no longer subject to backup withholding. **If the IRS has notified the Claimant(s) that he, she, or it is subject to backup withholding, please strike out the language in the preceding sentence indicating that the Claim is not subject to backup withholding in the certification above.**

UNDER THE PENALTIES OF PERJURY, I (WE) CERTIFY THAT ALL OF THE INFORMATION PROVIDED BY ME (US) ON THIS CLAIM FORM IS TRUE, CORRECT, AND COMPLETE, AND THAT THE DOCUMENTS SUBMITTED HEREWITH ARE TRUE AND CORRECT COPIES OF WHAT THEY PURPORT TO BE.

Signature of Claimant

Date

Print your name here

Signature of joint Claimant, if any

Date

Print your name here

If the Claimant is other than an individual, or is not the person completing this form, the following also must be provided:

Signature of person signing on behalf of Claimant

Date

Print your name here

Capacity of person signing on behalf of Claimant, if other than an individual, e.g., executor, president, trustee, custodian, etc. (Must provide evidence of authority to act on behalf of Claimant – see paragraph 13 on page 4 of this Claim Form.)

REMINDER CHECKLIST:

1. Please sign the above release and certification. If this Claim Form is being made on behalf of joint Claimants, then both must sign.
2. Remember to attach only **copies** of acceptable supporting documentation, as these documents will not be returned to you.
3. Please do not highlight any portion of the Claim Form or any supporting documents.
4. Do not send original security certificates or documentation. These items cannot be returned to you by the Claims Administrator.
5. Keep copies of the completed Claim Form and documentation for your own records.
6. The Claims Administrator will acknowledge receipt of your Claim Form by mail, within 60 days, or online, promptly after your submission. Your Claim is not deemed filed until you receive an acknowledgement. **If, after submitting your Claim Form by mail, you do not receive an acknowledgement postcard within 60 days, please call the Claims Administrator toll-free at 1-877-777-9675.**
7. If your address changes in the future, or if this Claim Form was sent to an old or incorrect address, please send the Claims Administrator written notification of your new address. If you change your name, please inform the Claims Administrator.
8. If you have any questions or concerns regarding your Claim, please contact the Claims Administrator at the address below, by email at info@HCSGSecuritiesLitigation.com, toll-free at 1-877-777-9675, or visit www.HCSGSecuritiesLitigation.com.

Please DO NOT call Healthcare Services Group or any of the other Defendants or their counsel with questions regarding your Claim.

THIS CLAIM FORM MUST BE MAILED TO THE CLAIMS ADMINISTRATOR BY FIRST-CLASS MAIL, POSTMARKED NO LATER THAN FEBRUARY 7, 2022, ADDRESSED AS FOLLOWS:

Healthcare Services Group Securities Litigation
c/o A.B. Data, Ltd.
P.O. Box 173002
Milwaukee, WI 53217

A Claim Form received by the Claims Administrator shall be deemed to have been submitted when posted if a postmark date on or before February 7, 2022 is indicated on the envelope and it is mailed First-Class and addressed in accordance with the above instructions. In all other cases, a Claim Form shall be deemed to have been submitted when actually received by the Claims Administrator.

You should be aware that it will take a significant amount of time to fully process all of the Claim Forms. Please be patient and notify the Claims Administrator of any change of address.