PROOF OF CLAIM AND RELEASE FORM

Deadline for Submission: August 15, 2017

IF YOU PURCHASED THE SECURITIES OF DS HEALTHCARE GROUP, INC. ("DS HEALTHCARE") ON THE NASDAQ DURING THE PERIOD FROM MAY 15, 2014 THROUGH APRIL 3, 2016, INCLUSIVE (THE "SETTLEMENT CLASS PERIOD"), YOU ARE A "SETTLEMENT CLASS MEMBER" AND YOU MAY BE ENTITLED TO SHARE IN THE SETTLEMENT PROCEEDS. (EXCLUDED FROM THE CLASS ARE: (I) DEFENDANTS; (II) FORMER OFFICERS, DIRECTORS, AND CONSULTANTS OF DS HEALTHCARE AND OF ANY OTHER RELEASED PARTIES; (III) DS HEALTHCARE HK LIMITED; (IV) PARENTS, SPOUSES, OR CHILDREN LIVING IN THE HOUSEHOLD OF ANY PERSON EXCLUDED UNDER (I) OR (II) ABOVE; (V) ANY LEGAL ENTITY MORE THAN 50% OWNED BY ANY PERSON EXCLUDED UNDER (I) AND (II) ABOVE; AND (VI) THE HEIRS, SUCCESSORS AND ASSIGNS OF ANY PERSON EXCLUDED UNDER (I) AND (II) ABOVE.)

IF YOU ARE A SETTLEMENT CLASS MEMBER, YOU MUST COMPLETE AND SUBMIT THIS FORM IN ORDER TO BE ELIGIBLE FOR ANY SETTLEMENT BENEFITS.

YOU MUST COMPLETE AND SIGN THIS PROOF OF CLAIM AND RELEASE FORM ("PROOF OF CLAIM AND RELEASE FORM") AND MAIL IT BY FIRST CLASS MAIL, POSTMARKED NO LATER THAN AUGUST 15, 2017 TO STRATEGIC CLAIMS SERVICES, THE CLAIMS ADMINISTRATOR, AT THE FOLLOWING ADDRESS:

In re DS Healthcare Group, Inc. Securities Litigation
c/o Strategic Claims Services
600 N. Jackson St., Ste. 3
P.O. Box 230
Media, PA 19063
Tel.: 866-274-4004
Fax: 610-565-7985
info@strategicclaims.net

YOUR FAILURE TO SUBMIT YOUR CLAIM BY AUGUST 15, 2017 WILL SUBJECT YOUR CLAIM TO REJECTION AND PRECLUDE YOU FROM RECEIVING ANY MONEY IN CONNECTION WITH THE SETTLEMENT OF THIS ACTION. DO NOT MAIL OR DELIVER YOUR CLAIM TO THE COURT OR TO ANY OF THE PARTIES OR THEIR COUNSEL AS ANY SUCH CLAIM WILL BE DEEMED NOT TO HAVE BEEN SUBMITTED. SUBMIT YOUR CLAIM ONLY TO THE CLAIMS ADMINISTRATOR. IF YOU ARE A SETTLEMENT CLASS MEMBER AND DO NOT SUBMIT A PROPER PROOF OF CLAIM AND RELEASE FORM, YOU WILL NOT SHARE IN THE SETTLEMENT BUT YOU NEVERTHELESS WILL BE BOUND BY THE ORDER AND FINAL JUDGMENT OF THE COURT UNLESS YOU EXCLUDE YOURSELF.

SUBMISSION OF A PROOF OF CLAIM AND RELEASE FORM DOES NOT ASSURE THAT YOU WILL SHARE IN THE PROCEEDS OF THE SETTLEMENT.

I. CLAIMANT INFORMATION

Name:		
Address:		
City:	State:	ZIP:
Foreign Province:	Foreign Country:	
Day Phone:	Evening Phone:	
Email:		
Social Security Number (for individuals):	OR	Taxpayer Identification Number (for estates, trusts, corporations, etc.):

II. SCHEDULE OF TRANSACTIONS IN DS HEALTHCARE COMMON STOCK

Please supply all required details of your transaction(s) in DS Healthcare common stock. Broker confirmations, brokerage statements reflecting your purchases, or other documentation of your transactions in DS Healthcare common stock should be attached to your claim. If you do not have documentation from your broker, you may also attach any documents or schedules that you attached to any federal tax return that reflect Settlement Class Period purchases, acquisitions or sales of DS Healthcare common stock. Failure to provide this documentation could delay verification of your claim or result in rejection of your claim.

If you are acting in a representative capacity on behalf of a Settlement Class Member (e.g., as an executor, administrator, trustee, or other representative), you must submit evidence of your current authority to act on behalf of that Settlement Class Member. Such evidence would include, for example, letters testamentary, letters of administration, or a copy of the trust documents.

Beginning Holdings:

A. State the total number of shares of DS Healthcare securities on NASDAQ held at the close of trading on May 14, 2014 (*must be documented)*. If none, write "zero" or "0." ☐

Purchases/Acquisitions:

B. Separately list each and every purchase or acquisition of DS Healthcare securities on NASDAQ from May 15, 2014 through April 3, 2016, both dates inclusive, and provide the following information (*must be documented):*

Trade Date (List Chronologically) (Month/Day/Year)	**Number of Shares Purchased/Acquired**	**Price per Share**	**Total Cost (Excluding Commissions, Taxes, and Fees)**

Sales:

C. Separately list each and every sale of DS Healthcare securities on NASDAQ from May 15, 2014 through April 3, 2016, both dates inclusive, and provide the following information (*must be documented*):

Trade Date (List Chronologically) (Month/Day/Year)	**Number of Shares Sold**	**Price per Share**	**Amount Received (Excluding Commissions, Taxes, and Fees)**

Ending Holdings:

D. State the total number of shares of DS Healthcare securities held at the close of trading on April 3, 2016 (*must be documented).*

If additional space is needed, attach separate, numbered sheets, giving all required information, substantially in the same format, and print your name and Social Security or Taxpayer Identification number at the top of each sheet.

III. SUBSTITUTE FORM W-9

Request for Taxpayer Identification Number:

Enter taxpayer identification number below for the Beneficial Owner(s). For most individuals, this is your Social Security Number. The Internal Revenue Service ("I.R.S.") requires such taxpayer identification number. If you fail to provide this information, your claim may be rejected.

Social Security Number (for individuals)	**or**	Taxpayer Identification Number (for estates, trusts, corporations, etc.)

IV. CERTIFICATION

I (We) submit this Proof of Claim and Release Form under the terms of the Stipulation of Settlement described in the Notice. I (We) also submit to the jurisdiction of the United States District Court for the Southern District of Florida, with respect to my (our) claim as a Settlement Class Member and for purposes of enforcing the release and covenant not to sue set forth herein. I (We) further acknowledge that I am (we are) bound by and subject to

the terms of any judgment that may be entered in this Action. I (We) have not submitted any other claim covering the same purchases or sales of DS Healthcare common stock during the Settlement Class Period and know of no other Person having done so on my (our) behalf.

UNDER THE PENALTIES OF PERJURY UNDER THE LAWS OF THE UNITED STATES, I (WE) CERTIFY THAT ALL OF THE INFORMATION I (WE) PROVIDED ON THIS PROOF OF CLAIM AND RELEASE FORM IS TRUE, CORRECT AND COMPLETE.

Signature of Claimant (If this claim is being made on behalf of Joint Claimants, then each must sign):

_____
(Signature)

_____
(Signature)

_____
(Capacity of person(s) signing, e.g. beneficial purchaser(s), executor, administrator, trustee, etc.)

☐ Check here if proof of authority to file is enclosed.

Date: _____

REMINDER CHECKLIST

- Please be sure to sign this Proof of Claim and Release Form above. If this Proof of Claim and Release Form is submitted on behalf of joint claimants, then both claimants must sign.
- Please remember to attach supporting documents. Do NOT send any stock certificates. Keep copies of everything you submit.
- Do NOT use highlighter on the Proof of Claim and Release Form or any supporting documents.
- If you move or change your address, telephone number or email address, please submit the new information to the Claims Administrator, as well as any other information that will assist us in contacting you. NOTE: Failure to submit updated information to the Claims Administrator may result in the Claims Administrator's inability to contact you regarding issues with your claim or delivery payment to you.

In re DS Healthcare Group, Inc. Securities Litigation
c/o Strategic Claims Services
600 N Jackson Street – Suite 3
Media, PA 19063

IMPORTANT LEGAL DOCUMENT – PLEASE FORWARD