Notice Administrator For Circuit Court
P.O. Box 2200
Faribault, MN 55021-1600

Legal Notice of Class Action Settlement Involving Liberty Policies.

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FOR OFFICIAL USE ONLY

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CLAIMANT SUBCLASS CLAIM FORM

Lebanon Chiropractic Clinic, P.C. v. Liberty Mutual et al. Class Action Settlement

This form is for Claimant Subclass members. For a Provider Subclass form, call 1-866-591-7240 or go to www.LebanonPipSettlement.com.

Fill out and submit this claim form if, between June 25, 2004 and October 31, 2014, you suffered injuries that were covered by the Personal Injury Protection (PIP) or Medical Payments (MedPay) coverage provided by a personal automobile policy issued by a "Liberty" insurer in a "Settlement State," (see below) received medical treatment for those injuries, sought payment for that treatment under the Liberty policy (or allowed someone else to seek payment on your behalf); and received from Liberty a total payment that was less than the amount billed because Liberty determined that the billed charge exceeded the usual, customary, or reasonable allowance. Read the notice to learn more about eligibility and benefits available.

"Liberty" insurers are: Liberty Mutual Insurance Company, Liberty Mutual Fire Insurance Company, The First Liberty Insurance Corporation, Liberty Personal Insurance Company, Liberty Insurance Corporation, Liberty Lloyds of Texas Insurance Company, LM General Insurance Company, LM Personal Insurance Company, Safeco Insurance Company of America, Safeco Insurance Company of Illinois, Safeco Insurance Company of Indiana, Safeco Insurance Company of Oregon, Safeco National Insurance Company, Safeco Surplus Lines Insurance Company, General Insurance Company of America, First National Insurance Company of America, American States Insurance Company, American States Preferred Insurance Company, and American Economy Insurance Company.

The "Settlement States" are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin and Wyoming.

Please print clearly in blue or black ink. This Claim Form must be mailed and postmarked by **April 6, 2015**. Remember to sign your Claim Form before you mail it and include all requested documentation that you have available.

1. Class Member Information.

Name: _____

Number and Street: _____

City: _____ State: ____ ____ Zip Code: ____ ____ ____ ____ ____

Contact Name: _____

Daytime Phone: (____ ____ ____) ____ ____ ____ - ____ ____ ____ ____

2. Claim Information.

Page 2 of this claim form requests information regarding the treatment for which you seek payment. If you seek payment for more than one treatment, please photocopy Page 2 and complete a separate copy regarding each treatment for which you seek payment.

3. Required Documentation.

You need to attach any of the following that you have in your possession:

- Any documents you received from Liberty regarding the claim, including Explanations of Benefits (EOBs), Explanations of Payments (EOPs), or Explanations of Reviews (EORs), and correspondence regarding the claim; and
- Any documents showing whether any person other than Liberty was billed for–or paid–any of the cost of any covered treatment (e.g., copies of any EOBs, EOPs, or EORs, medical bills, correspondence, and/or insurance claim forms related to the covered treatment and copies of any cancelled checks or other documents demonstrating payment for the covered treatment).

4. Sign and Date Your Claim Form.

I certify under penalty of perjury that I have read this Claim Form; I believe I am eligible for Class Membership; all of the information on this Claim Form is true and correct to the best of my knowledge; I have made a diligent search for the documents described in Part 3 above; and I have attached to or enclosed with this Claim Form all such documents that I have been able to locate.

Signature: _____ Date: ____ ____ / ____ ____ / ____ ____ ____ ____

Print Name: _____

5. Mail Your Claim Form.

Claim Form must be postmarked by **April 6, 2015** and mailed to:

Liberty Lebanon Claims
P.O. Box 1986
Faribault, MN 55021-6182

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CFW

CLAIM INFORMATION ABOUT TREATMENTS.

Please provide the following information regarding the treatment for which you seek payment under the settlement. If you seek payment for more than one treatment, please photocopy this page as necessary and complete a separate copy regarding each treatment for which you seek payment.

a. Name of person treated: _____

b. Number and Street: _____

c. City: _____ State: ____ ____ Zip Code: ____ ____ ____ ____ ____

d. Approximate Date of Accident: ____ ____ / ____ ____ / ____ ____ ____ ____

e. Approximate Date of Treatment: ____ ____ / ____ ____ / ____ ____ ____ ____

f. Nature of the treatment: _____

g. Approximate date Claim was submitted to Liberty: ____ ____ / ____ ____ / ____ ____ ____ ____

h. Liberty Policy Number (if known): _____

i. Liberty Claim Number (if known): _____

j. Total amount billed by your Medical Provider for the treatment: $ _____

k. Total amount paid by Liberty for the treatment: $ _____

l. Did your Medical Provider bill you for any amount unpaid by Liberty?: _____

m. If you received a bill from your Medical Provider for a balance unpaid by Liberty, how much, if anything, did you pay in response to that bill?

$ _____

n. Did another insurance company (or anyone else) reimburse you for the amount, if any, you paid in response to that bill? _____

A NOTE ABOUT CLAIMS ADMINISTRATION.

Please be patient. If your claim is approved, you will receive a letter telling you what your payment will be. The letter will explain the process and deadlines to resolve any disagreement you may have with your payment amount.