

**Legal Notice of Class Action
Settlement Involving
Liberty Policies.**



FOR OFFICIAL USE ONLY
03

PROVIDER SUBCLASS CLAIM FORM

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

This form is for Provider Subclass members. For a Claimant 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 provided medical treatment to a member of the Claimant Subclass; sought payment under the Personal Injury Protection (PIP) or Medical Payments (MedPay) coverage provided by a personal automobile policy issued by "Liberty" in a "Settlement State," and received from Liberty a total payment that was less than the amount billed for that treatment 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/or 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/or 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.

1. Class Member Information.

Name: _____

Tax Payer Identification: _____

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 under the settlement. In lieu of answering questions a-k, you may attach a copy of the latest EOR you received regarding the treatment. If you seek payment for more than one treatment, please photocopy Page 2 and complete a separate copy (and provide a separate EOR) 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





CLAIM INFORMATION ABOUT TREATMENTS.

Please provide the following information regarding the treatment for which you seek payment under the settlement. In lieu of answering questions a-k, you may attach a copy of the latest EOB, EOP, or EOR you received regarding the treatment. 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 you submitted Claim to Liberty: ____ / ____ / _____
- h. Liberty Policy Number (if known): _____
- i. Liberty Claim Number (if known): _____
- j. Total amount you billed for this treatment: \$ _____
- k. Total amount paid by Liberty for this treatment: \$ _____
- l. Amount, if any, you billed to Patient/Claimant for any balance unpaid by Liberty: \$ _____
- m. If you sent a bill to the Patient/Claimant for the balance unpaid by Liberty, how much, if anything, did you receive in response to that bill:
\$ _____
- n. Amount, if any, you billed to any other insurance company for this treatment: \$ _____
- o. If you sent a bill to another insurance company for this treatment, how much did you receive 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.