Farmers/Zurich PPO Settlement
PO Box 2594
Faribault, MN 55021-9594

FOR OFFICE USE ONLY

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1234597890

[NAME1]
[NAME2]
[NAME3]
[ADDR1]
[ADDR2]
[CITY STATE ZIP CODE]

☐ If the pre-printed information to the left is not correct or if there is no pre-printed information, please check the box and complete the information below:

Name: _____

Address: _____

City: _____

State: ___ ___ Zip Code: ___ ___ ___ ___ ___

REQUEST FORM

To make a claim for a settlement payment, complete and sign this form and mail it along with the required documentation to the address listed below, postmarked no later than May 30, 2012:

A. YOUR INFORMATION

Name: _____

Address: _____

City: _____ State: ___ ___ Zip Code: ___ ___ ___ ___ ___

Telephone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ OR Tax Id Number: ___ ___ - ___ ___ ___ ___ ___ ___ ___

B. CLAIM INFORMATION

To be eligible in accordance with the full terms and conditions of the Settlement Agreement to receive a payment of eighty percent (80%) of the amount of the CCN/First Health PPO reduction applied by Farmers Defendants Mid-Century Insurance Company **or** Illinois Farmers Insurance Company **on medical bills submitted to the Farmers Defendants for payment under an automobile policy, you must supply all required information and documentation, answer the following questions, and sign this Form to certify the information provided. Your claim is subject to review, audit and challenge, and any payment for which you are approved is subject to policy limits and to offset by payments to you received from any other source for the medical services.**

I am enclosing or attaching copies of the following documentation: (a) explanation of review(s) ("EOR"), explanation of payment, explanation of benefits, or other similar documents received from or on behalf of, the Defendants or (b) business records that were created based on or from EORs or similar documents received from, or on behalf of, the Defendants. The documentation provided must contain at least the amount of the PPO reduction, the name of the claimant/patient and the date(s) of service, and contain the claim number, if available.

The documentation shows $ _____ in PPO reductions applied by the Farmers Defendants *Mid-Century Insurance Company* or *Illinois Farmers Insurance Company* between January 1, 2001 and March 1, 2004.

Have you received payment for the medical services identified in the documentation from any source other than *Mid-Century Insurance Company* or *Illinois Farmers Insurance Company*?	☐ Yes ☐ No

If you answered "Yes," then Defendants may request additional information to confirm that you are eligible for benefits under the Settlement.

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C. ADDITIONAL INFORMATION

In addition to the Claim Information required in section B, you are requested to provide the following information, if available, for each claimant/patient identified in the documentation you are submitting with this Request Form. This information will be used solely to verify your claim and to comply with any applicable Medicare Secondary Payer Act reporting requirements.

Patient's First and Last Name:	
Patient's Date of Birth:	
Patient's Gender:	☐ M ☐ F
Patient's Social Security Number or Health Insurance Claim Number:	
Patient's Last Known Address:	
Defendants' Claim Number:	

Under penalties as provided by law pursuant to Section 1-109 of the Illinois Code of Civil Procedure, the undersigned certifies that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that he or she verily believes the same to be true.

Signature: _____ Date: __ __ / __ __ / __ __ __ __

Mail a copy of this claim form and any required documentation, postmarked no later than May 30, 2012, to:

Farmers/Zurich PPO Settlement
PO Box 2594
Faribault, MN 55021-9594

Telephone: 1-800-657-1974, Website: www.pposettlements.com