RESPONSE DUE DATE
Postmarked or Submitted Online By October 25, 2019

Syndicate Settlement
c/o A.B. Data, Ltd.
P.O. Box 173075
Milwaukee, WI 53217

FOR OFFICIAL USE ONLY

SYNDICATE SETTLEMENT CLAIM FORM

If you are a Settlement Class Member as defined on page 2 of the Notice of Proposed Partial Class Action Settlement, Settlement Hearing and Right to Appear ("Notice") with respect to the purchase of insurance coverage from the Defendants described on page 2 of the Notice where the coverage incepted or renewed during the period January 1, 1997, through March 25, 2019, you must complete the following form for each such insurance that you purchased or renewed and mail it to the address listed above in order to participate in the Settlement for such policies. You may also complete the form online at www.SyndicateSettlement.com. This claim form must be postmarked or submitted online by **October 25, 2019**.

Claimant Information

Contact Name

Contact Title

Company/Organization/Insured Name

Address

City

State

Zip Code

Phone Number/Extension

Email Address

Policy Information

Name(s) of Lloyd's Syndicate(s)	Policy Number	Total Premium Paid ($000,000.00)	Date of Policy (MM/DD/YYYY)

Broker Name

Broker Street Address

Broker City	Broker State	Broker Zip Code	Broker Phone Number

I certify under the penalty of perjury that the information above is true and correct and that the submission of false information may subject me to civil and/or criminal penalties.

_____ Signature

___ ___/___ ___/___ ___ Date

_____ Print Name

_____ Title

Name(s) of Lloyd's Syndicate(s)		Policy Number	Total Premium Paid ($000,000.00)	Date of Policy (MM/DD/YYYY)
Broker Name				
Broker Street Address				
Broker City	Broker State	Broker Zip Code	Broker Phone Number	

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Broker Name				
Broker Street Address				
Broker City	Broker State	Broker Zip Code	Broker Phone Number	

IF YOU NEED ADDITIONAL SPACE TO LIST YOUR TRANSACTIONS YOU MUST PHOTOCOPY THIS PAGE AND CHECK THIS BOX ☐