

Holden v. Farmers Insurance Company
P.O. BOX 2615
FARIBAULT MN 55021-9615

FOR OFFICE USE ONLY

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[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: _____
E-mail: _____
Telephone: (____) _____ - _____

CLAIM FORM

Insurance Actual Cash Value ("ACV") Litigation
Farmers Insurance Company of Washington and Farmers Insurance Exchange

THIS CLAIM FORM MUST BE POSTMARKED NO LATER THAN FEBRUARY 28, 2012, TO BE VALID. THE COMPLETED CLAIM FORM SHOULD BE MAILED TO:

**HOLDEN V. FARMERS INSURANCE COMPANY
P.O. BOX 2615
FARIBAULT MN 55021-9615**

For each claim you must fill out as much of this Claim Form as you are able to in order to determine whether your Claim qualifies you as a member of the Class. Please complete the claim form to the best of your ability based on your own knowledge or records. You will be contacted by the Settlement Administrator if the information you have provided cannot be verified.

1. Name of Policy Holder at Time of Loss	
2. Address of Policy Holder at Time of Loss	
3. State where Insurance Policy Issued	
4. Insurance Policy Number, if known	
5. Claim Number, if known	
6. Date of Loss, if known	
7. Insuring Company (check one):	<input type="checkbox"/> Farmers Insurance Company of Washington <input type="checkbox"/> Farmers Insurance Exchange <input type="checkbox"/> Other Farmers entity
8. Did you submit a contents claim for personal property damage under your homeowner's and/or renter's policy?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE
9. Did you receive sales tax on the actual cash value settlement of your claim?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE
10. Did you make a replacement cost claim for all of your personal property items that were a total loss?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT SURE

PLEASE ATTACH ANY DOCUMENTS YOU HAVE RELATED TO YOUR INSURANCE CLAIM.

(Continued on reverse side)



I declare under penalty of perjury under the laws of the State of Washington that the information supplied on this Claim Form by the undersigned is true and correct to the best of my recollection, and that this form was executed on the date set forth below.

Date: _____, 2011 _____

Signature (REQUIRED)

Print Name (REQUIRED)

Street Address (REQUIRED)

City (REQUIRED)

State (REQUIRED)

Zip Code (REQUIRED)

(____) _____ - _____
Telephone Number (REQUIRED)

