

**CLAIM FORM**

**Instructions:**

**YOU DO NOT NEED TO COMPLETE THIS FORM IN ORDER TO PARTICIPATE IN THE CLASS SETTLEMENT BASED ON A PRESUMED RETURN OF 30% OF SUBROGATION ALLSTATE COLLECTED WITH RESPECT TO YOUR CLAIM.**

**1. If you believe your uncompensated losses (losses for which you have not already been paid), exceed 30% of that subrogation amount, you may make a claim for all such losses by (a) completing this claim form, (b) providing any documentation you have of the claimed losses, and (c) providing a phone number and hours during which you are most easily contacted at that number by the independent adjuster.**

**2. The claim form must be mailed to the class administrator on or before March 30, 2019.**

**3. Based upon an independent evaluation of your claim for uncompensated losses, a final non-appealable determination will be reached that may be either greater or lesser than 30%, but in no case greater than 100% of subrogation Allstate collected with respect to your claim.**

In your claim, the Allstate Defendants brought a subrogation claim based on the following auto accident:

- Insured Name:**
- Accident Date:**
- Claim Number:**
- Amount (Ins. Co.) Paid On Your Claim:**

Allstate Defendants recovered subrogation on your claim in the amount of \$\_\_\_\_\_.

Please print (or type) clearly in blue or black ink. Please sign the form and submit all documentation YOU MAY HAVE supporting your unpaid losses or expenses fitting within the categories described below.

**1. GENERAL INFORMATION**

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Daytime Phone: (\_\_\_\_)\_\_\_\_\_ Evening Phone: (\_\_\_\_)\_\_\_\_\_

Name of person listed on insurance policy, if not you: \_\_\_\_\_

If you are acting on behalf of a Class Member, state your relationship: \_\_\_\_\_

**2. LOSS/ACCIDENT INFORMATION**

Please identify below whether you have any such outstanding expenses (those for which you have not been compensated), and that amount. IF YOU DO NOT KNOW THE EXACT AMOUNTS, PLEASE ESTIMATE THE AMOUNTS.

**A.** Any medical expenses (past and future), lost wages, personal injury (including but not limited to permanent impairment, pain, suffering, present and future loss of earning capacity, necessary purchases, the value of services supplied or purchased, loss of established course of life, and emotional distress and property loss damages sustained in the auto accident);

DO YOU HAVE ANY DAMAGES OF THIS TYPE? YES \_\_\_ NO \_\_\_  
AMOUNT: \$ \_\_\_\_\_.

**B.** The amount of any incidental losses caused by the auto accident such as towing expenses, loss of use, and loss of profits;

DO YOU HAVE ANY DAMAGES OF THIS TYPE? YES \_\_\_ NO \_\_\_  
AMOUNT: \$ \_\_\_\_\_.

**C.** The amount of any loss of use damage. Loss of use is the value of a reasonable replacement vehicle for each day your automobile was being repaired or for each day that you were without an automobile for a reasonable time after your automobile was declared a total loss. If you were provided with a rental vehicle that was the relative equivalent of your automobile, you probably do not have loss of use;

DO YOU HAVE ANY DAMAGES OF THIS TYPE? YES \_\_\_ NO \_\_\_

If so, please state:

Number of days you were without use of your vehicle: \_\_\_\_\_

Your estimate of the per day reasonable rental value of substitute vehicle: \_\_\_\_\_

**D.** The amount of any residual diminution in value of your repaired vehicle. Residual diminution in value is the difference you would receive for your automobile upon sale or trade in after it has been repaired and what you would have received for your automobile upon sale or trade in if it had not been damaged in the accident;

DO YOU HAVE ANY DAMAGES OF THIS TYPE? YES \_\_\_ NO \_\_\_  
AMOUNT: \$ \_\_\_\_\_.

**E.** The amount of any expense (including attorney's fees) to obtain relief from insurance or the tortfeasor;

DO YOU HAVE ANY DAMAGES OF THIS TYPE? YES \_\_\_ NO \_\_\_  
AMOUNT: \$ \_\_\_\_\_.

**F.** The amount of your unreimbursed deductible for the losses and damages;

DO YOU HAVE ANY DAMAGES OF THIS TYPE? YES \_\_\_ NO \_\_\_  
AMOUNT: \$ \_\_\_\_\_.



**3. SIGN AND DATE YOUR FORM**

I certify under the law applicable to fraudulent insurance claims that I have read this form and all of the above information on this Form is correct to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Month/Day/Year

**4. MAIL YOUR FORM**

This form must be postmarked by March 30, 2019 and mailed to:

Konecky v. Allstate Class Administrator  
c/o JND Legal Administration  
P.O. Box 91350  
Seattle, WA 98111

**5. ADMINISTRATION PROCESS**

Please be patient. You will either be contacted by a Claims Adjuster or receive a letter telling you the amount that the Claims Adjuster has determined to be the amount of your claim for proportional participation in the Class Settlement. If you have any questions, please call counsel for the class at:

**Allan M. McGarvey**  
(406) 752-5566

**Judah M. Gersh and  
Brian M. Joos**  
(406) 862-7800

**Alan J. Lerner**  
(406) 756-9100

or write to class counsel at:

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