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### Belanger v. Allstate Claim Form

**TO SUBMIT A VALID CLAIM, THIS CLAIM FORM MUST BE POSTMARKED BY FEBRUARY 5, 2024 AND RETURNED TO:**

**Belanger v. Allstate Settlement Administrator  
P.O. Box 2317  
Portland, OR 97208-2317**

If you make a claim for payment on this Claim Form, and if your claim is deemed valid and the settlement is finally approved, an email will be sent from [noreply@epiqpay.com](mailto:noreply@epiqpay.com) to the email address you provided on this Claim Form, prompting you to elect your method of payment. Popular electronic payment options will be available, or you can elect to receive a check. Please ensure you have provided a current and complete email address. If you do not provide a current and valid email address, the Settlement Administrator may attempt to send you a check relying on your physical address on file.

*All information listed below is required. We will use this information to contact you and process your claim. It will not be used for any other purpose. If any of the following information changes, you must promptly notify the Settlement Administrator using the contact section of [NewMexicoAllstateClassAction.com](http://NewMexicoAllstateClassAction.com) or by writing to the address above.*

Claimant's First Name	MI	Last Name
<input type="text"/>	<input type="text"/>	<input type="text"/>

Insurance Policy Number	Insurance Claim Number
<input type="text"/>	<input type="text"/>

Business Name

Primary Address

City	State	ZIP Code
<input type="text"/>	<input type="text"/>	<input type="text"/>

Phone Number

 -  - 

Email Address



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## SETTLEMENT OPTIONS

Check the box(es) below for the Settlement benefit options.

- Option 1** - Check this box if you believe you made or could have made an Underinsured Motorist (“UIM”) claim to Allstate between January 1, 2004 and your first policy renewal after July 11, 2022 for an automobile accident that may have been subject to an offset in coverage due to the insurance coverage limits of a third party responsible for your injuries or property damage. You may be required to submit additional evidence to receive payment, such as medical records or medical bills.
- Option 2** - Check this box if you would like a partial refund of UM/UIM premiums paid. Your refund will be either 12% of all premiums paid for minimum limits, non-stacked UM/UIM coverage or 18% of all premiums paid for all other UM/UIM coverage between January 1, 2004 and your first policy renewal after July 11, 2022.

### Claimant ID\* (on the notice mailed or emailed to you)

Claimant ID

PIN

\*Contact the Settlement Administrator at 1-888-294-7563 if you cannot find or do not have a Claimant ID and PIN.

## Signature

I affirm under the laws of the United States that the information supplied in this claim form is true and correct to the best of my knowledge and that any documents that I have submitted in support of my claim are true and correct copies of original documentation. I understand that I may be asked to provide more information by Allstate before my claim is complete.

Signature

Date:   -   -      
MM DD YYYY

Print Name