

RESPONSE DUE DATE
Postmarked By
_____, 2007

GALLAGHER SETTLEMENT
CLAIM FORM
IBGA

Official Use Only

PLEASE NOTE: If you are a Settlement Class Member (see Notice Section 4), *you must complete the reverse side of this Claim Form for each eligible policy and mail it to the address listed below in order to participate in the settlement for such policies.* This claim form must be **postmarked by _____, 2007.** generally, a eligible policy is either (i) a policy purchased or renewed during the period August 26, 1994 through December 31, 2005 (the "Class Period") where any related broker, administrative, advisor or claim services were provided by Gallagher or (ii) you purchased or renewed an insurance policy from any insurer during the Class Period through any of the Broker Defendants described at Section 2 of the Notice, other than Gallagher. **Please refer to Section 4 of the Notice for a more detailed explanation as to who is a Settlement Class Member.** If you have questions as to whether you are a Settlement Class Member you can contact the Settlement Administrator at 1-800-XXX-XXXX or visit www.insurancebrokerageantitrustlitigation.com.

PART I - CLAIMANT IDENTIFICATION: *(Please print or type)*

_____ Company/Organization Name	_____ Name	/	_____ Title
_____ Street Address	_____ City	_____ State	_____ Zip Code
(_____) _____ Area Code Telephone Number			

CLAIM DOCUMENTATION INSTRUCTIONS: Complete the following information including **Broker Information** (name of broker, address, phone number), and **Policy Information** (insurance company, policy number, year of inception or renewal and premium paid). Please provide the required information for each broker and the premium paid for each year from August 26, 1994 through September 1, 2005 inclusive. **YOU MUST MAIL YOUR COMPLETED AND SIGNED PROOF OF CLAIM TO THE SETTLEMENT ADMINISTRATOR POSTMARKED BY _____, 2007.**

If you require additional space, attach extra copies of Part II and/or Part III in the same format as below.
Sign and print your name on each additional page.

PART II - BROKER INFORMATION, if applicable: *(Please print or type)*

_____ Broker Name	(_____) _____ Area Code Telephone Number
_____ Street Address	_____ City State Zip Code

Mail by _____, 2007 to: Insurance Brokerage Antitrust Litigation, c/o Complete Claim Solutions, LLC,
P.O. Box _____, West Palm Beach, FL 33416

If you require additional space, attach extra copies of Part II and/or Part III in the same format as below.
Sign and print your name on each additional page.

PART III - POLICY INFORMATION: <i>(Please print or type)</i>			
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
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Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____

** (Inception/Renewal)

I certify under 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: _____ Email Address: _____
 Print Name and Title: _____ Date: _____

NOTE: The Settlement Administrator is authorized to request, from persons or entities submitting this form, any documentation necessary to verify all information appearing in the Claim Form or to prevent consideration of duplicate claims submitted by or on behalf of a class member. Failure to provide such information in response to such request may constitute grounds for rejection of the Claim.

Mail by _____, 2007 to: Insurance Brokerage Antitrust Litigation, c/o Complete Claim Solutions, LLC,
 P.O. Box _____, West Palm Beach, FL 33416