UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA
Richard Behfarin v. Pruco Life Ins. Co., The Prudential Ins. Co. of America, and Pruco Life Ins. Co. of New Jersey,
Case No. 2:17-cv-05290-MWF-FFM

CLAIM FORM FOR INDIVIDUALIZED RELIEF

Class Settlement
[c/o Settlement Administrator]
Toll-Free Number: 1-855-915-0909
Email: info@LapsedPolicySettlement.com
Website: www.LapsedPolicySettlement.com

TO BE CONSIDERED FOR INDIVIDUALIZED RELIEF IN CONNECTION WITH THE PROPOSED SETTLEMENT, YOU MUST COMPLETE AND SIGN THIS CLAIM FORM. YOU MAY ALSO USE THIS CLAIM FORM FOR BASIC RELIEF.

This Claim Form is for the Lapsed/Deceased Population. The Lapsed/Deceased Population is defined by the Settlement Agreement and includes Settlement Class Members associated with policies that lapsed for a final time during the Class Period and were not reinstated, where the insured(s) is (are) deceased. This includes Policyowners of such a Class Policy, and where the Policyowner(s) also is (are) no longer living, then also the designated beneficiaries of that Class Policy.

Do not use this Claim Form if any insured on the Class Policy is still living. A different Claim Form and different Settlement relief is available if an insured is still living, as described in the Class Notice. You may obtain the Claim Form for policies where the insured is still living either by contacting the Claims Administrator or by electronically submitting or downloading the Claim Form found on the Claims Administration website at www.LapsedPolicySettlement.com.

YOU MAY SUBMIT THIS FORM ELECTRONICALLY ON THE CLAIMS ADMINISTRATION WEBSITE AT www.LapsedPolicySettlement.com **BY 11:59 P.M. PST on March 31, 2020**; OR MAIL IT TO THE CLAIMS ADMINISTRATOR BY FIRST-CLASS MAIL, **POSTMARKED NO LATER THAN March 31, 2020**.

IF YOUR CLAIM IS NOT SUBMITTED OR MAILED BY THE ABOVE DATE, YOU WILL NOT BE ELIGIBLE TO PARTICIPATE IN ANY SETTLEMENT RELIEF PROVIDED BY THE PROPOSED SETTLEMENT. WHETHER OR NOT YOU SUBMIT A CLAIM, IF YOU HAVE NOT REQUESTED TO BE EXCLUDED FROM THE CLASS, YOU WILL BE BOUND BY THE RELEASES IN THE SETTLEMENT AGREEMENT INCLUDING THE COVENANT NOT TO SUE. ALL CLASS MEMBERS ARE BOUND BY THE ORDERS OF THE COURT.

PLEASE READ

YOUR CLAIM IS NOT DEEMED FILED UNTIL YOU RECEIVE AN ACKNOWLEDGEMENT. THE CLAIMS ADMINISTRATOR WILL ACKNOWLEDGE RECEIPT OF YOUR CLAIM FORM BY MAIL OR BY EMAIL, IF YOU HAVE PROVIDED AN EMAIL ADDRESS, WITHIN 10 DAYS. IF YOU DO NOT RECEIVE AN ACKNOWLEDGEMENT WITHIN 10 DAYS, CALL THE CLAIMS ADMINISTRATOR TOLL FREE AT 1-855-915-0909.

DO NOT MAIL OR DELIVER YOUR CLAIM FORM TO THE COURT, THE PARTIES TO THIS ACTION, OR THEIR COUNSEL. SUBMIT YOUR CLAIM FORM ONLY TO THE CLAIMS ADMINISTRATOR AS SET FORTH ABOVE.

PLEASE KEEP A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS.

TABLE OF CONTENTS **PAGE #**

PART I – GENERAL INSTRUCTIONS

1. It is important that you read the Class Notice posted on the Settlement Website (the "Class Notice" or "Notice") along with this Claim Form. The Class Notice includes the definition of the Settlement Class, describes the various forms of relief that are offered by the Proposed Settlement to Authorized Claimants, and explains how the Settlement Class is affected by the Proposed Settlement and the manner in which Settlement Class Members may participate. The Notice also contains the definitions of many of the defined terms (which are indicated by initial capital letters) used in this Claim Form. By signing and submitting this Claim Form, you certify that you have read and that you understand the Class Notice, including the terms of the Releases described in the Class Notice.

2. By submitting this Claim Form, you are certifying that the policy on which you are making a Claim was a universal life or variable universal life insurance policy issued by Prudential (including Pruco Life Insurance Company, The Prudential Insurance Company of America, or Pruco Life Insurance Company of New Jersey) that lapsed between July 18, 2013, and November 26, 2019. You further represent that you were a Policyowner of that policy, i.e. that you are an individual who owned and was responsible for payments on the policy when it was in force; or that you are an authorized representative of a Policyowner or the Estate of a Policyholder (if deceased), or that you were a designated beneficiary of that policy (or an authorized representative of a designated beneficiary.) If you do not meet this description, please do not submit this Claim Form for Individualized Relief.

3. After submission of your Claim, the Claims Administrator will determine if you are a Class Member, and an Authorized Claimant for Individualized Relief.

The Settlement Class is defined as:

> All Policyowners of Class Policies and, where all Policyowners and insureds of a Class Policy are deceased, then also any designated beneficiary(ies) of that Class Policy at the time of final lapse.
>
> Class Policies include all individual universal life or variable universal life insurance policies issued by a Defendant as to which Guaranteed Charges were applicable to the calculation of the deficiency and/or reinstatement amount, and which policy either entered into default or lapsed between July 18, 2013, and the date of Preliminary Approval, or which had default cured or was reinstated on or after July 18, 2013, and remains in force on the date of Preliminary Approval.

4. If the Claims Administrator determines that you are not a Settlement Class Member, **you may not, directly or indirectly, participate in the Settlement and any Claim Form that you submit, or that may be submitted on your behalf, will not be accepted.** Even if you are not a Settlement Class Member, if you have a connection to a Class Policy, you may still be bound by the orders of this Court.

5. If you submitted a request for exclusion from the Class, submission of this Claim Form will supersede your request to be excluded. That means you will now be bound by the terms of the Settlement.

6. By submitting a Claim Form, you are requesting Individualized Relief for the Lapsed/Deceased Population which allows Authorized Claimants Individualized Relief for Class Policies in the form of a monetary Settlement Payment, the amount of which will be determined by a Claim Scoring Process conducted by the Claims Administrator.

7. **Please be aware that if you make a Claim and the Claims Administrator approves Individualized Relief, you agree to assume all responsibilities and liabilities associated with distribution of the Settlement Payment under law, including making any payments that may be owed to others. Your agreement to assume liability and all other obligations for receiving the Individualized Relief are also stated in the Notice and the Settlement Agreement.**

8. After submission of your Claim, the Claims Administrator will determine if you are an Authorized Claimant, and will apply the Scoring Process. The Scoring Process is based on an individual analysis and determination of each Claim according to Scoring Guidelines. The score will depend upon what that evidence reflects regarding whether, and how, you may have been impacted (if at all) by the conduct alleged in the Action.

9. **Submission of this Claim Form does not guarantee that you will receive Individualized Relief, Basic Relief, or any relief at all. The procedures for the determination of your Claim are set forth in the Proposed Settlement and Exhibits.**

10. Use Part III of this Claim Form to supply all required information to request Individualized Relief. You must provide all required documentation listed below to support your Claim. **Failure to provide this information during the requested time period may result in rejection of your Claim**.

11. If you do not want to request Individualized Relief, you may also submit this Claim Form to request the Basic Relief alternative.

12. All Claimants must sign this Claim Form and their names must appear as "Claimants" in Part II of this Claim Form.

13. If the Court approves the Proposed Settlement, all relief determined as part of the claims process will be provided to Claimants pursuant to the Settlement Agreement after any appeals are resolved, and after the completion of all claims processing. The claims process will take substantial time to complete fully and fairly. Please be patient.

14. If you have questions concerning the Claim Form, or need additional copies of the Claim Form or the Notice, you may contact the Claims Administrator, at the below address, by email at info@LapsedPolicySettlement.com, by toll-free phone at 1-855-915-0909, or you can visit the Settlement website, www.LapsedPolicySettlement.com, where copies of the Claim Form and Notice are available for downloading.

IMPORTANT: You are required to submit true and correct information when completing the Claim Form. **DO NOT MAKE ANY CHANGES TO THIS FORM. Failure to provide true and correct information can result in denial of your Claim under the Settlement.**

PART II – CLAIMANT IDENTIFICATION

Please complete this PART II in its entirety. The Claims Administrator will use this information for all communications regarding this Claim Form. If this information changes, you MUST notify the Claims Administrator in writing using the contact information above.

Claimant's Name (First/Middle Initial/Last) [please insert the name of the person submitting this form and making the Claim. Do not insert the name of the deceased here]

First Name | MI | Last Name

Claimant's Current Address

City | State | ZIP Code

Country

Joint Claimant's Name (First/Middle Initial/Last) [if there is no other Claimant, skip this section]

First Name | MI | Last Name

Joint Claimant's Current Address

City | State | ZIP Code

Country

Telephone Number 1 (Daytime)

___ – ___ – ____

Telephone Number 1 (Evening)

___ – ___ – ____

If you provide a mobile phone number, you are authorizing the Claims Administrator to contact you on your mobile phone and agree to pay any associated charges with calls to your mobile phone.

Email Address 1 (Email address is not required, but if you provide it, you authorize the Claims Administrator to use it in providing you with information relevant to this Claim.)

Policy Number (if available)

PART III – REQUEST FOR INDIVIDUALIZED RELIEF

Complete this Part III if you would like to make a Claim for Individualized Relief.

We will use the Claimant(s) information provided above for this Claim. In addition, please provide the following information.

INSURED INFORMATION: [Please provide the name of the now-deceased individual who was insured by the Class Policy here]

1. Name of Insured (First/Middle Initial/Last):

First Name | MI | Last Name

2. Alias, Former or Maiden Name (if any)*:

3. Last Telephone Number*:

– –

4. Last Address*:

City | State | ZIP Code

5. The Insured's Date of Birth:

– –

MM DD YYYY

6. The Insured's Date of Death:

– –

MM DD YYYY

7. The Insured's Social Security Number*:

– –

OTHER INSURED [Applicable to survivorship policies only. Please provide the name of the second now-deceased individual who was insured by the Class Policy here]:

1. Name of Second Insured (First/Middle Initial/Last):

First Name | MI | Last Name

2. Alias, Former or Maiden Name (if any)*:

3. Last Telephone Number*:

– –

4. Last Address*:

City | State | ZIP Code

* This information is to be provided to the extent you have it.

5. The Other Insured's Date of Birth:

MM – DD – YYYY

6. Other Named Insured's Date of Death:

MM – DD – YYYY

7. The Other Named Insured's Social Security Number*:

POLICYOWNER INFORMATION: [The Policyowner is the individual who owned the Class Policy when it was in force. Information on the insured is requested above. Please provide all available information].

1. Was the Policyowner Also the Insured? ☐ Yes ☐ No

2. Is the Policyowner Also the Claimant? ☐ Yes ☐ No

3. Name of Policyowner (First/Middle Initial/Last):

First Name MI Last Name

4. Any Change of His or Her Name in the Last Five Years? If yes, provide former name*:

5. Telephone Number*:

6. Address*:

City State ZIP Code

OTHER POLICYOWNER INFORMATION (if more than one Policyowner):

1. Is the Other Policyowner Also an Insured? ☐ Yes ☐ No

2. Is the Other Policyowner Also a Claimant? ☐ Yes ☐ No

3. Name of Other Policyowner (First/Middle Initial/Last):

First Name MI Last Name

4. Any Change of His or Her Name in the Last Five Years? If yes, provide former name*:

5. Telephone Number*:

6. Address*:

City State ZIP Code

* This information is to be provided to the extent you have it.

CLAIMANT'S CERTIFICATIONS, ATTESTATIONS, AND WARRANTIES

Check the box that applies to you:

☐ I am the sole Policyowner of the Class Policy at the time of final lapse;

☐ I am an authorized representative of the sole Policyowner of the Class Policy at the time of final lapse (e.g., the Administrator or Executor of the Estate of an insured Policyowner);

☐ I am one of two or more Policyowners of a Class Policy at the time of final lapse;

☐ I am an authorized representative of one of two or more Policyowners of the Class Policy at the time of final lapse (e.g., the Administrator or Executor of the Estate);

☐ I am the sole beneficiary of the Class Policy at the time of final lapse and the sole Policyowner is deceased;

☐ I am one of two or more beneficiaries of the Class Policy at the time of final lapse and the sole Policyowner is deceased; or

☐ I am an authorized representative of a beneficiary or beneficiaries of the Class Policy at the time of final lapse and the sole Policyowner is deceased.

Complete one of the below sections if it applies to you:

<u>If one of two or more Policyowners:</u>

☐ I (we) have authority to act on the Class Policy by consent from any/all individuals or entities who were Policyowners at the time of final lapse;

[OR]

☐ I (we) am (are) one of (part of) two or more Policyowners and have proof that other Policyowner(s) is (are) deceased or cannot be located.

<u>If an authorized representative of a Policyowner Estate:</u>

☐ By making this Claim as an authorized representative, I (we) agree to assume all obligations and responsibility for distribution of any Settlement Payment pursuant to law.

<u>If you are one of two or more living Beneficiaries:</u>

☐ I (we) have authority to act on the Class Policy by consent from any/all other individuals or entities who were Beneficiaries at the time of final lapse;

[OR]

☐ I (we) have proof that other Beneficiary(ies) is (are) deceased or cannot be located.

AND:

☐ I (we) agree to assume all obligations and responsibility for distribution of any Settlement Payment pursuant to law, including (where relevant) any other beneficiaries on the Class Policy.

SUPPORTING DOCUMENTATION ESTABLISHING RIGHT TO CLAIM

Proof of Claimant's Identity

The Claims Administrator will cross-reference the proof of identity you provide against Company Records to verify that you are the Policyowner of the Class Policy or otherwise have an interest in the policy and are entitled to collect a Settlement Payment.

As such, you must provide the following information with your Claim:

Proof of your identity to establish interest in the Class Policy. [Proof of identity may include: a copy of a current valid passport, naturalization certificate, driver's license, military ID card, or other current government-issued identification.]

If you are a Policyowner on a Class Policy and have changed your name such that it no longer matches the name of the Policyowner listed on the Class Policy, you must also provide a certified copy of the applicable name change document, such as a marriage certificate, divorce decree, or court order.

If you are an authorized representative of a Policyowner or beneficiary, such as the Executor, Administrator, or other person with legal authority to act on another's behalf, you must provide a copy of the legal document(s) conferring on you the authority to act on behalf of the Policyowner or beneficiary. Acceptable documents include (for example) copies of executed trust agreements, wills, guardianship papers, court orders, or power of attorney forms.

If you are one of multiple persons or entities with an ownership interest or right in a Class Policy, you must provide either: (i) notarized copies of signatures granting you permission to obtain the Settlement Payment; or (ii) proof that other Policyowner(s) or beneficiaries are deceased or cannot be located (in accordance with the proof of death requirements set forth below). In any event, **you must agree to assume all responsibilities and liabilities associated with distribution of the Settlement Payment under law, including making any payments that may be owed to others, as set forth in further detail in the Attestations and Warranties section of Claim Form.**

Proof of Insured(s) Death

You must also provide proof of the death of all persons insured under the Class Policy. Proof of death of an insured must be in the form of a certified copy of the insured's death certificate (electronic and photocopies are permitted). This can be secured from the Bureau of Vital Statistics or Department of Health for the city, county, or state in which the death occurred.

If the death occurred outside the United States, proof of death can be either in the form of a certified copy of the public record of death from that country, or a report of death by a United States consul or agent of the State Department bearing the official seal.

If there have been any changes to the name of the insured such that the name listed on the death certificate is not identical to that on the Class Policy, you must provide a certified copy of the applicable name change document, such as a marriage certificate, divorce decree, or court order. The Claims Administrator will cross-reference the proof of death you provide against Company Records and public records to verify that the decedent is the Class Policy's insured.

Evidence of Other Insurance

If, at any time after default of the Class Policy, any other life insurance policy was purchased or obtained on the life of the insured on the Class Policy, you must provide evidence of that insurance, including its face amount, the period of time the policy was in force, and the name of the issuing company. If a death benefit has been claimed or paid by any insurer, you must provide evidence of that claim and/or payment.

IMPORTANT: Documents submitted to the Claims Administrator in support of your Claim will not be returned.

If the Claim Form is incomplete or missing supporting documentation, the Claims Administrator will notify you in writing at the address provided on the Claim Form. The notification will set forth the deficiencies in the submitted Claim Form, and will provide an opportunity for you to cure those deficiencies within ten (10) business days from the date of the notice.

If you fail to properly complete the Claim Form and provide the necessary supporting documentation, the Claims Administrator will not be required to determine whether you are an Authorized Claimant and no Settlement Payment will be made.

ATTESTATIONS AND WARRANTIES:
I (we) attest and warrant each of the following statements, and so reflect with my (our) initials and signature below.

IF ANY OF THESE STATEMENTS ARE NOT TRUE AS TO YOU, DO NOT INITIAL THE STATEMENT.
Do not make any changes to the form.

I (we) am or stand in the shoes of the Policyowner of the Class Policy and/or was (were) a designated beneficiary of the Class Policy at time of final lapse and am (are) entitled to collect a Settlement Payment. **[Claimant(s) initials]**

☐☐

I (we) assume all responsibilities and liabilities associated with distribution of the Settlement Payment under law, including making any payments that may be owed to others. **[Claimant(s) initials]**

☐☐

I (we) acknowledge that all persons claiming an interest or right in the Class Policy(ies) must act jointly in exercising any right such as making this Claim (or any right to exclude him or herself from the Class or to object to the Settlement). **[Claimant(s) initials]**

☐☐

I (we) understand that the Claims Administrator is the sole determiner of whether I (we) am (are) (an) Authorized Claimant(s). **[Claimant(s) initials]**

☐☐

I (we) attest that I (we) have disclosed on this Claim Form any life insurance purchased or obtained on the life of the insured on the Class Policy following default, and have disclosed any death benefit claimed or received. **[Claimant(s) initials]**

☐☐

I (we) understand that there is no recourse to the Court or any other regulatory or judicial body for any determination made by the Claims Administrator pursuant to the Settlement Agreement. **[Claimant(s) initials]**

☐☐

I (we) understand that the Claims Administrator will determine the Final Score for my (our) Claim and that I (we) will only have a limited appeal to the Special Master upon notification that I (we) qualify. If I (we) have the right to appeal the Final Score to the Special Master, I (we) will be responsible for paying the $1,000 cost of appeal. **[Claimant(s) initials]**

☐☐

I (we) understand that any payment is a Settlement Payment and is not a death benefit payment (or any other type of payment) under the terms of the Class Policy. **[Claimant(s) initials]**

☐☐

By signing this Claim Form, I (we) swear to the truth of the statements contained herein and the genuineness of the information provided in the submission of this Claim, subject to penalties of perjury under the laws of the United States of America. I (we) understand that the making of false statements may result in the rejection of this Claim; it may further subject me (us) to civil liability or criminal prosecution.

I (we) hereby acknowledge that, pursuant to the terms set forth in the Settlement, I (we) am (are) bound by all provisions of the Settlement and all orders of the Court including without limitation the Release and Covenant Not to Sue.

I (we) acknowledge that the decision to participate in the Settlement was mine (ours). It was not made based upon advice from Prudential or anyone acting on its behalf, or at the direction or counsel of any Party.

Claimant(s) Signature(s): Date: MM – DD – YYYY

Claimant(s) Signature(s): Date: MM – DD – YYYY

AUTHORIZATION TO RELEASE INFORMATION

By signing below, I (we) authorize any insurance company or producer and the Medical Information Bureau, Inc. ("MIB"), to give information about me (us) to the Claims Administrator, Prudential, and/or its authorized agents to determine information related to my Claim for Settlement relief.

I (we) further acknowledge and agree that Defendants will be providing Prudential Records, including Class Policy records, for each Settlement Class Member and each insured on a Class Policy to the Claims Administrator. I (we) acknowledge and agree that the Prudential Records are likely to include personal information, and may include Social Security numbers, individually identifiable health information, policy information, and financial information, among other things. I (we) request that the Claims Administrator review the Prudential Records in order to adjudicate my (our) Claim(s). I (we) understand that the Settlement provides that all Prudential Records held by the Claims Administrator shall be confidential and shall not be subject to publication or disclosure by the Claims Administrator. I (we) understand that no person other than the Parties, their attorneys (including their consultants and experts who are bound by a Protective Order in the Action), the Claims Administrator, the Special Master, and the Court shall be permitted to obtain or review any Claim Form, or any decision of the Claims Administrator with respect to accepting or rejecting any Claim, except as provided for in the Settlement Agreement or upon Court Order for good cause shown.

Claimant(s) Signature(s): Date: MM – DD – YYYY

Claimant(s) Signature(s): Date: MM – DD – YYYY

REMINDER CHECKLIST

1. Sign the above Release and Certification. If this Claim Form is being made by more than one Claimant, then all Claimants must sign.

2. Review your responses to the Claim Form for accuracy.

3. Be sure you have attached a copy of the insured's death certificate(s) and any other supporting documentation.

4. Keep copies of the completed Claim Form for your own records.

5. The Claims Administrator will acknowledge receipt of your Claim Form by mail, or email if you provided an email address, within 10 days. Your Claim is not deemed filed until you receive an acknowledgement. **(If you do not receive an acknowledgement within 10 days, please contact the Claims Administrator as provided below.)**

6. If your address changes, or if this Claim Form was sent to an old or incorrect address, you must send the Claims Administrator written notification of your new address. If you change your name, inform the Claims Administrator. If any of your responses to the Certifications or Attestations you provided change, you must inform the Claims Administrator.

7. If you have any questions or concerns regarding your Claim, please contact the Claims Administrator at the address below, by email at info@LapsedPolicySettlement.com, by toll-free phone at **1-855-915-0909**, or you may visit www.LapsedPolicySettlement.com. DO NOT call Defendants or their counsel with questions regarding your Claim.

THIS CLAIM FORM MUST EITHER BE ELECTRONICALLY SUBMITTED ON THE CLAIMS ADMINISTRATION WEBSITE AT www.LapsedPolicySettlement.com **BY 11:59 P.M. PST on March 31, 2020**; OR BE MAILED TO THE CLAIMS ADMINISTRATOR BY FIRST-CLASS MAIL, **POSTMARKED NO LATER THAN March 31, 2020**, ADDRESSED AS FOLLOWS:

Prudential Class Settlement
c/o Claims Administrator
P.O. Box 6869
Portland, OR 97228-6869

A Claim Form received by the Claims Administrator shall be deemed to have been submitted when posted, if a postmark date on or before **March 31, 2020** is indicated on the envelope and it is mailed First-Class, and addressed in accordance with the above instructions. In all other cases, a Claim Form shall be deemed to have been submitted when actually received by the Claims Administrator.