

SWISS BANKS SETTLEMENT INSURANCE POLICY CLAIMS FORM

FOR OFFICE USE ONLY
CLAIM NUMBER

DATE

CONFIDENTIAL CLAIM FORM

Please fill in this form as completely as possible and to the best of your knowledge. You **must** answer each question marked with a black numbered box (for example **2.1**) so we can proceed with your claim.

Estimates or approximations based on your knowledge may be helpful and should be included, however, please do not guess at any answers. Responses such as "don't know" or "not applicable" or "can't remember", for example, are acceptable. If you need more space please use the last page for any extra information. If you are claiming for more than one policy, please complete a separate form for each policy.

Please be sure that you have (1) signed Declaration of Consent and Release, Covenant Not To Sue and Jurisdictional Acknowledgement in the space provided, (2) enclosed proof of identity (e.g. copy of passport), and (3) enclosed any other documents and/or statements and/or information substantiating your claim.

New List of 36 Names of Holocaust-Era Insurance Policyholders

This claim seeks compensation for a policy owned by a policyholder included on the New List of 36 Names of Holocaust-Era Insurance Policyholders. The name of the policyholder from the List is: _____

0.1 Signature of claimant _____

Place signed _____

Date signed _____ DAY /MONTH /YEAR

0.2 If you have a representative he/she must sign here

Signature of representative _____

Place signed _____

Date signed _____ DAY /MONTH /YEAR

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GENERAL INFORMATION

1

1 Was the policyholder, beneficiary and/or insured a Victim or Target of Nazi Persecution?

The term "policyholder" refers to the person who bought the insurance contract. The term "beneficiary" refers to the person entitled to receive the insurance payment. Note that the term "insured person" refers to the person who was covered by the insurance.

Yes No

Victim or Target of Nazi Persecution means any individual, corporation, partnership, sole proprietorship, unincorporated association, community, congregation, group, organization, or other entity persecuted or targeted for persecution by the Nazi Regime because they were or were believed to be Jewish, Romani, Jehovah's Witness, homosexual, or physically or mentally disabled or handicapped.

1

INFORMATION ABOUT YOURSELF

Please add a copy of your passport/identity card/
driver's license/other form of official documentation.
Do not send us the original.

2.1 Last name **2.1**

2.2 First name **2.2**

2.3 Middle names(s) 2.3

2.4 Maiden name (if applicable) **2.4**

2.5 Sex Male Female 2.5

2.6 Name changes including changes of spelling (if any) 2.6
(Please provide the date of the name change, and
if available, official documentation)

2.7 Date of birth (day/month/year) 2.7

2.8 Place of birth (country/state/city) 2.8

2.9 Citizen 2.9
When was it acquired if not by birth?
All former citizenship (if any) and from when
to when?

2.10 Current address **2.10**

Please include country
and area codes for
telephone/fax numbers

Street, No.
City
State
Zip Code
Country
Telephone
Fax

2.11 Name, address and telephone number of a
relative of yours 2.11

3.1 Name of company

- I do not know
- The reasons I believe that one of the Participating Insures Carriers issued the policy are

3.2 Place where insurance policy was purchased

Country

State

City

3.3 Other information which might support the search (e.g. name of insurance agent or intermediary who sold the policy, letterhead, corporate logo etc).

4.1 Can you provide us with copies of any document and/or statement and/or other information substantiating your claim?

- No Yes

- If yes:
- policy
 - correspondence
 - premium payments
 - other documents and/or statements and/or other information, please specify:

TO ENSURE PROMPT AND ACCURATE PROCESSING OF YOUR CLAIM PLEASE ENCLOSE COPIES OF ALL DOCUMENTS IN YOUR POSSESSION.

- 5.1 Type of insurance policy 5.1
- Life insurance
 Annuity
 Endowment
 Dowry or education
 Other, please specify:
-
-
- 5.2 Policy number 5.2
-
- 5.3 Currency 5.3
-
- 5.4 Face Value 5.4
-
- 5.5 Date of issue (Reasonable estimates of the date the policy was purchased/issued, based on your knowledge, may be helpful to determine your claim and should be included. However, if you have no reasonable idea when the policy was issued/purchased, please do not guess) 5.5
-
- 5.6 Date of maturity 5.6
-

5.7 Are you aware of any payments out of the insurance policy? **5.7**

Yes No

If yes:

When?

To Whom?

Amount?

Please specify type of payment below:

Payment to a blocked account

(an account held in the policyholder's name to which access was restricted i.e. transactions were possible only when permitted by government)

Payment to a government following confiscation of the policy

(policy was confiscated by government and proceeds were subsequently to be paid by company directly to government)

Policy loan or advance

(a loan against the policy provided by the insurance company to the policyholder)

Surrender payment

(early surrender of policy to the company in order to receive the surrender value in cash)

Settlement payment

(payment by the insurance company to settle a claim relating to the policy, including upon maturity of the policy or the death of the insured)

- 5.8 Mode of payment of the premium: 5.8
 Single payment
 Weekly/monthly/annual payment
-
- 5.9 Amount of premium 5.9
-
- 5.10 To the best of your knowledge, 5.10
 were all premiums paid?
 If not, for how long were payments made?
 Why were the payments stopped?
-
- 5.11 Has anybody approached the insurance company about 5.11
 this insurance policy?
 If yes, please specify name, year etc.
 (Please attach copies of all relevant correspondence with
 the insurance company)

6 POLICYHOLDER 6

The term "policyholder" refers to the person who bought the insurance contract. Please write the name as it would appear on an official document such as an insurance policy and include known alternative spellings.

- 6.1** Last name of policyholder **6.1**
-
- 6.2** First name of policyholder **6.2**
-
- 6.3 Middle name(s) of policyholder 6.3
-
- 6.4** Maiden name of policyholder (if applicable) **6.4**
-
- 6.5 Sex Male Female 6.5
-
- 6.6** **6.6**
 Name changes including changes of spelling (if any), and, if available, official documents relating to the name change.
-
- 6.7 Any other names used by policyholder 6.7
 (including aliases)
-
- 6.8** Date of birth of Policyholder (day/month/year) **6.8**
-
- 6.9** Place of birth of policyholder (country/state/city) **6.9**
-
- 6.10 If applicable date (day/month/year) and place of death of 6.10
 policyholder or best approximation
-

- 6.11** *Citizenship of policyholder* **6.11**
 When was it acquired if not by birth? _____
 All former citizenship (if any) and from when to when? _____

-
- 6.12 Former known place(s) of residence of policyholder before 1945 including stays in camps, ghettos etc. **6.12**
 For how long did the policyholder stay at these places?
 Please add dates where possible

-
- 6.13 If the policyholder was insured by his/her employer, what was the policyholder's profession and name of employer until 1945? **6.13**

-
- 6.14 What is your relationship to the policyholder (e.g. husband, wife, child, etc.)? **6.14**

-
- 6.15** *Do you know of any other living heirs of the policyholder?* **6.15**
 Yes No
 If yes, please indicate names and addresses

7 **INSURED PERSON(S)** **7**

The term "insured person" refers to the person who was covered by the insurance policy.

- 7.1** *Last name of insured person(s)* **7.1**

- 7.2** *First name of insured person(s)* **7.2**

- 7.3 Middle name(s) of insured person(s) **7.3**

- 7.4** *Maiden name of insured person(s) (if applicable)* **7.4**

- 7.5 Sex Male Female **7.5**
- 7.6 Name changes including changes of spelling (if any) **7.6**

7.7 Any other names used by insured person(s) (including aliases) 7.7

7.8 Date of birth of insured person(s) (day/month/year) **7.8**

7.9 Place of birth of insured person(s) (country/state/city) **7.9**

7.10 If applicable date (day/month/year) and place of death of insured person(s) – or best approximation 7.10

7.11 Citizenship of insured person(s) **7.11**

When was it acquired if not by birth?
All former citizenship (if any) and from when to when?

7.12 Former known place(s) of residence of insured person(s) before 1945 including stays in camps, ghettos etc. 7.12

For how long did the insured person(s) stay at these places?
Please add dates where possible

7.13 What is your relationship to the insured person(s) (e.g. husband, wife, child etc.)? 7.13

7.14 Do you know of any other living heirs of the insured person(s)? **7.14**

Yes No

If yes, please indicate names and addresses

The term "beneficiary" refers to the person named in the policy as entitled to receive the insurance payment.

8.1 Last name of beneficiary 8.1

8.2 First name of beneficiary 8.2

8.3 Middle name(s) of beneficiary 8.3

8.4 Maiden name of beneficiary (if applicable) 8.4

8.5 Sex Male Female 8.5

8.6 Name changes including changes of spelling (if any) 8.6

8.7 Any other names used by beneficiary (including aliases) 8.7

8.8 Date of birth of beneficiary (day/month/year) 8.8

8.9 Place of birth of beneficiary (country/state/city) 8.9

8.10 If applicable date (day/month/year) and place of death of beneficiary - or best approximation 8.10

8.11 Citizenship of beneficiary 8.11

When was it acquired if not by birth?
All former citizenship (if any) and from when to when?

8.12 Former known place(s) of residence of beneficiary before 1945 including stays in camps, ghettos etc. 8.12

For how long did the beneficiary stay in these places?
Please add dates where possible

8.13 What is your relationship to the beneficiary
(e.g. husband, wife, child etc.)?

8.13

8.14 Do you know of any other living heirs of
the beneficiary?

8.14

Yes No

If yes, please indicate names and addresses

9

COMPENSATION

9

9.1 Have you or any else participated in any
compensation/restitution procedure for this claim

9.1

Yes No I do not know

If yes, please check all that apply
(please add BEG or other procedure register number)

Deutsche Wiedergutmachung, Bundesentschädigungsgesetz (BEG)

Bundesrückerstattungsgesetz (BRüG)

International Commission on Holocaust-Era Insurance Claims (ICHEIC)

German Foundation Initiative (GFI)

Österreichisches Entschädigungsgesetz

U.S. Foreign Claims Settlement Commission

Other, please specify: _____

If yes, how much was paid and to whom?

If you applied, but no payment was received, why not?

IS ANYONE REPRESENTING YOU? (Representation is not required)

If yes, you need to complete this section.

Please make sure that your representative signs the first page of this form and the Declaration of Consent.

10.1 Representative's last name 10.1

10.2 Representative's first name 10.2

10.3 Representative's middle name(s) 10.3

10.4 Representative's law firm, company, or other organization name (where applicable) 10.4

Multiple horizontal lines for entering organization name.

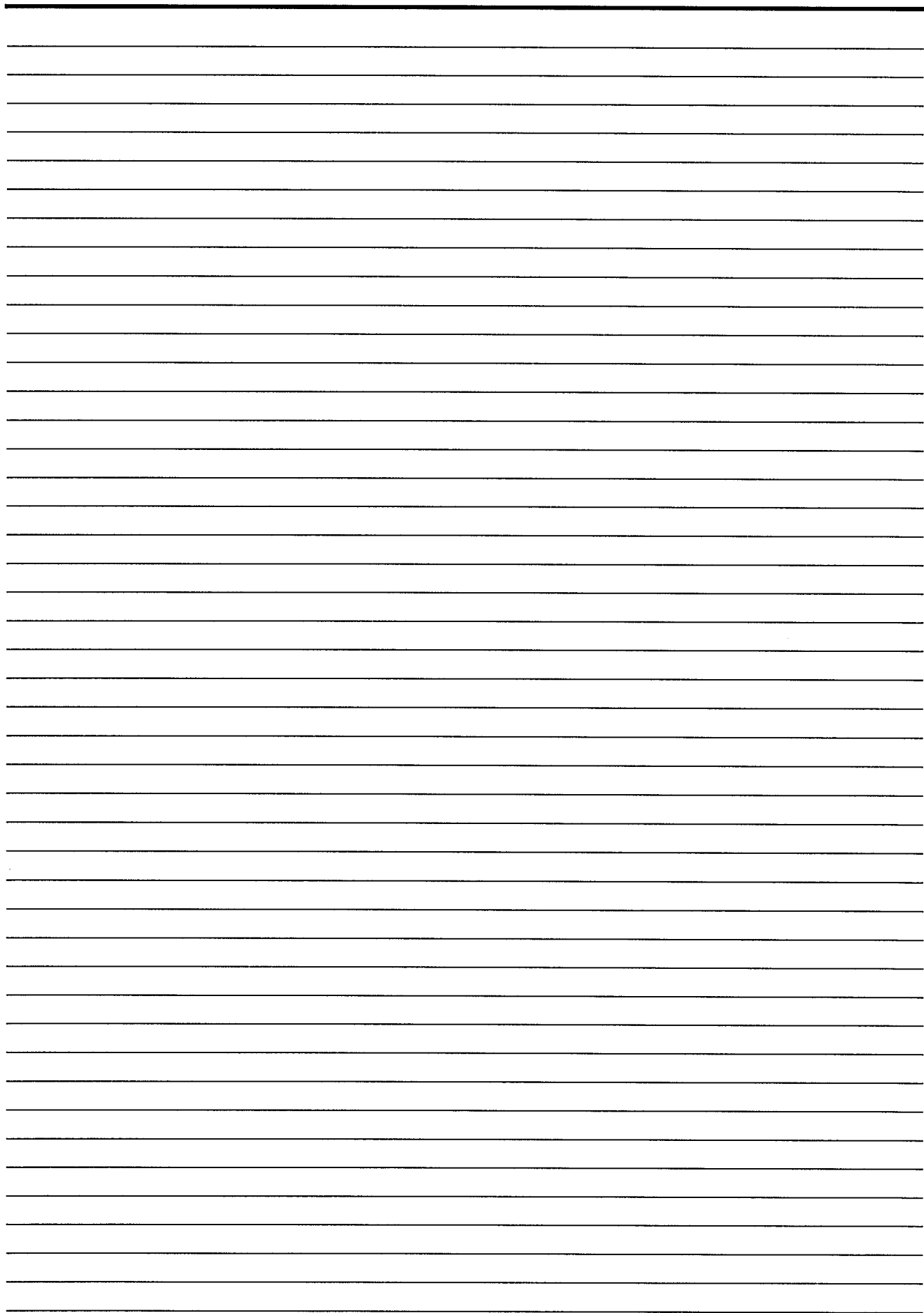
10.5 Representative's address Street, No. 10.5

Please include country and area codes for telephone/fax numbers

City, State, Zip/Post Code, Country, Telephone, Fax

11.1 Please add any other information which might be helpful 11.1

Multiple horizontal lines for entering further information.



DECLARATION OF CONSENT AND PROXY

The undersigned hereby authorizes the Participating Insurance Carriers and the Claims Resolution Tribunal ("CRT") to investigate the claim described in the Swiss Banks Settlement Insurance Policy Claims Form (the "Claim") and further authorizes them to make and use copies of documents containing personal data and to use such data to investigate the Claim.

All of the documents described in this Declaration of Consent shall be used only to investigate and/or process the Claim.

The undersigned acknowledges that in order to carry out these investigations, it may be necessary for the Participating Insurance Carriers or the CRT to process personal data. Such data may include sensitive personal data (as defined in European Directive no 95/46, the Data Protection Act 1998 (U.K.), the Swiss Federal Data Protection Act 1992, and other applicable national data protection acts).

Participating Insurance Carriers or the CRT may also need to disclose such data to third parties and to transfer such data to jurisdictions outside the European Economic

Area and/or Switzerland (even if such jurisdictions do not provide the same or equivalent level of protection for personal data as exists in the European Economic Area and/or Switzerland).

The undersigned hereby consents to such processing, disclosure or transfer.

The undersigned also authorizes investigations in all relevant governmental authorities, non-governmental organizations and relevant archives and for such authorities/bodies/organizations to give all requested information, including, without limitation, photocopies of relevant archival materials, to the Participating Insurance Carriers. To facilitate that process the undersigned hereby grants the Participating Insurance Carriers and the CRT power of attorney to obtain all information needed to clarify if the policies described in the Claim were confiscated by the Nazi Regime, if they were subject to restitution proceedings by the Federal German Republic and if restitution was paid. The undersigned also grants the Participating Insurance Carriers and the CRT power of attorney to obtain copies of the available documents.

JURISDICTIONAL ACKNOWLEDGEMENT

The undersigned hereby acknowledges that, as set forth in Amendment No. 2 to the Swiss Settlement, participation by a Participating Insurance Carrier in the Swiss Settlement shall not subject the Participating Insurance Carrier to the Jurisdiction of the United States District Court for the Eastern District of New

York or any other state or federal court in the United States, and, as is further set forth in Amendment No. 2 to the Swiss Settlement, the parties to the Settlement shall not argue that any Participating Insurance Carrier is subject to such jurisdiction.

SIGNATURES

By signing below, you agree to the Declaration of Consent, Release and Covenant Not To Sue, and Jurisdictional Acknowledgement above.

NB: All lines must be completed. If answer unknown, write in UNKNOWN.
If signature omitted, write a reason - e.g., DECEASED, LOST CONTACT

1. Name of Claimant _____ Signature _____
Date of Birth DAY /MONTH /YEAR _____ Date signed _____
Place of Birth _____ Place signed _____
Address of Claimant _____

2. Name of Policyholder _____ Signature _____
Date of Birth DAY /MONTH /YEAR _____ Date signed _____
Place of Birth _____ Place signed _____
Claimant's relationship to Policyholder _____ or reason for omission of signature _____
Address of Policyholder _____

3. Name of Insured _____ Signature _____
Date of Birth DAY /MONTH /YEAR _____ Date signed _____
Place of Birth _____ Place signed _____
Claimant's relationship to Insured _____ or reason for omission of signature _____
Address of Insured _____

4. Name of the Beneficiary _____ Signature _____
Date of Birth DAY /MONTH /YEAR _____ Date signed _____
Place of Birth _____ Place signed _____
Claimant's relationship to Beneficiary _____ or reason for omission of signature _____
Address of Beneficiary _____

SIGNATURE OF CLAIMANT'S REPRESENTATIVE
If you have a representative (e.g. attorney) he /she should sign this Declaration of Consent below.

5. Name of Representative _____ Signature _____
Date signed _____
Place signed _____