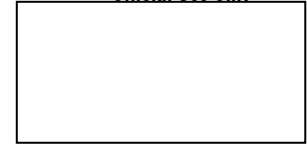


**RESPONSE DUE DATE**  
*Postmarked By*  
**NOVEMBER 16, 2007**

**GALLAGHER SETTLEMENT  
 CLAIM FORM**



**PLEASE NOTE:** If you are a Settlement Class Member (see Notice paragraph 4), *you must complete 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 November 16, 2007.** Generally, an 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 paragraph 2 of the Notice other than Gallagher. **Please refer to paragraph 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 1-866-459-3650 or visit [www.gallaghersettlement.com](http://www.gallaghersettlement.com).

**CLAIM DOCUMENTATION INSTRUCTIONS FOR PARTS I, II, III AND IV:**

1. ALL CLAIMANTS: Complete the Claimant Identification in Part I.
2. COMPANY CLAIMANTS:
  - a. In the appropriate blanks in Part II and Part III, fill in the names and addresses of any Gallagher Entity brokers or other Defendant Brokers that placed coverage for you during the Class Period (see endnotes for the identities of these brokers);
  - b. For claims on commercial policies, enter the **Policy Information** (insurance company, policy number, year of inception or renewal and premium paid) in Part II;
  - c. For claims on employee benefits policies, enter the number of covered employees per year and indicate by an "X" the types of insurance provided in each year in Part III; and
  - d. Every employee benefits claimant must check one of two boxes indicating that either (a) it has posted a notice to its employees indicating that they may be eligible to make a claim, or (b) the entity making the claim is no longer in business. (Part V, page 5)
3. EMPLOYEE CLAIMANTS:
  - a. Fill in the name of your employer in Part IV; and
  - b. Indicate by an "X" the benefit or benefits you received and contributed to each year in Part IV.
4. Please provide the required information for each entity and/or broker(s) for each year from August 26, 1994 through December 31, 2005 inclusive.
5. Sign the Certification (Part VI, page 5) at the end of this form.
6. **YOU MUST MAIL YOUR COMPLETED AND SIGNED PROOF OF CLAIM TO THE SETTLEMENT ADMINISTRATOR POSTMARKED BY NOVEMBER 16, 2007.**

**NOTE:** The Settlement Administrator is authorized to request, from persons or entities submitting this Claim 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 Settlement Class Member. Failure to provide such information in response to such request may constitute grounds for rejection of the Claim Form.



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

\* Please check the box at the left if the street address entered below is different from the address printed on the mailing page.

Company/Organization Name	Name	/	Title	
Street Address*	City	State	Zip Code	
( )	Area Code Telephone Number		Company FEIN / Last 4 digits of SSN if filing individually	



**Mail by November 16, 2007 to:** Gallagher Insurance Brokerage Antitrust Settlement, c/o Complete Claim Solutions, LLC,  
 P.O. Box 24749, West Palm Beach, FL 33416

**PART II – CLAIMS ON COMMERCIAL INSURANCE**

**A. COMMERCIAL INSURANCE YOU PURCHASED THROUGH A GALLAGHER ENTITY<sup>1</sup>, if applicable: (Please print or type)**

\_\_\_\_\_  
 Name of Gallagher Entity that placed your policy  
 (Refer to endnote 1, page 5, for list of Gallagher Entities)

(        )  
 Area Code

\_\_\_\_\_  
 Telephone Number

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City

\_\_\_\_\_  
 State

\_\_\_\_\_  
 Zip Code

**POLICY INFORMATION: (Please print or type)**

Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____

\*\* (Inception/Renewal)

**B. COMMERCIAL INSURANCE YOU PURCHASED THROUGH COMMERCIAL BROKER DEFENDANTS<sup>2</sup> OTHER THAN A GALLAGHER ENTITY<sup>1</sup>, if applicable: (Please print or type)**

\_\_\_\_\_  
 Name of Commercial Broker Defendant that placed your coverage  
 (Refer to endnote 2, page 5, for list of Commercial Broker Defendants)

(        )  
 Area Code

\_\_\_\_\_  
 Telephone Number

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City

\_\_\_\_\_  
 State

\_\_\_\_\_  
 Zip Code

**POLICY INFORMATION: (Please print or type)**

Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____
Insurance Company: _____	Policy Number: _____	Year** _____	Premium Paid \$ _____

\*\* (Inception/Renewal)

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



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Mail by November 16, 2007 to: Gallagher Insurance Brokerage Antitrust Settlement, c/o Complete Claim Solutions, LLC, P.O. Box 24749, West Palm Beach, FL 33416

**PART III – EMPLOYER CLAIMANTS ONLY: CLAIMS ON EMPLOYEE BENEFITS POLICIES**

**A. EMPLOYEE BENEFITS INSURANCE YOU PURCHASED THROUGH A GALLAGHER ENTITY<sup>1</sup>, if applicable: (Please print or type)**

\_\_\_\_\_  
 Name of Gallagher business that placed your coverage  
 (Refer to endnote 1, page 5, for list of Gallagher Entities)

\_\_\_\_\_  
 Area Code

\_\_\_\_\_  
 Telephone Number

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City

\_\_\_\_\_  
 State

\_\_\_\_\_  
 Zip Code

**Instructions:** Please fill in the number of covered employees per year and indicate with an "X" each type of coverage that you supplied to them each year.

	# Covered Employees	Health	Dental	Life	Long Term Disability	Short Term Disability	Vision
1994							
1995							
1996							
1997							
1998							
1999							
2000							
2001							
2002							
2003							
2004							
2005							

**B. EMPLOYEE BENEFITS INSURANCE YOU PURCHASED THROUGH EB BROKER DEFENDANTS<sup>3</sup> OTHER THAN A GALLAGHER ENTITY<sup>1</sup>, if applicable: (Please print or type)**

\_\_\_\_\_  
 Name of EB Broker Defendant that placed your coverage  
 (Refer to endnote 3, page 5, for list of EB Broker Defendants)

\_\_\_\_\_  
 Area Code

\_\_\_\_\_  
 Telephone Number

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City

\_\_\_\_\_  
 State

\_\_\_\_\_  
 Zip Code

**Instructions:** Please fill in the number of covered employees per year and indicate with an "X" each type of coverage that you supplied to them each year.

	# Covered Employees	Health	Dental	Life	Long Term Disability	Short Term Disability	Vision
1994							
1995							
1996							
1997							
1998							
1999							
2000							
2001							
2002							
2003							
2004							
2005							

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



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Mail by November 16, 2007 to: Gallagher Insurance Brokerage Antitrust Settlement, c/o Complete Claim Solutions, LLC,  
 P.O. Box 24749, West Palm Beach, FL 33416

**PART IV – EMPLOYEE CLAIMANTS ONLY: CLAIMS ON EMPLOYEE BENEFITS POLICIES**

**A. CLAIMS ON EMPLOYEE BENEFITS POLICIES PURCHASED BY YOU OR YOUR EMPLOYER THROUGH A GALLAGHER ENTITY<sup>1</sup>, if applicable:**  
 (Refer to endnote 1, page 5, for list of Gallagher Entities) (Please print or type)

\_\_\_\_\_  
 Name of employer that provided your employee benefits

( )  
 Area Code

\_\_\_\_\_  
 Telephone Number

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City

\_\_\_\_\_  
 State

\_\_\_\_\_  
 Zip Code

**Instructions:** Please indicate by an "X" the benefit or benefits you received and contributed to each year.

	Health	Dental	Life	Long Term Disability	Short Term Disability	Vision
1994						
1995						
1996						
1997						
1998						
1999						
2000						
2001						
2002						
2003						
2004						
2005						

**B. CLAIMS ON EMPLOYEE BENEFITS POLICIES PURCHASED BY YOU OR YOUR EMPLOYER THROUGH EB BROKER DEFENDANTS<sup>3</sup> OTHER THAN A GALLAGHER ENTITY<sup>1</sup>, if applicable:** (Refer to endnote 3, page 5, for list of EB Broker Defendants) (Please print or type)

\_\_\_\_\_  
 Name of employer that provided your employee benefits

( )  
 Area Code

\_\_\_\_\_  
 Telephone Number

\_\_\_\_\_  
 Street Address

\_\_\_\_\_  
 City

\_\_\_\_\_  
 State

\_\_\_\_\_  
 Zip Code

**Instructions:** Please indicate by an "X" the benefit or benefits you received and contributed to each year.

	Health	Dental	Life	Long Term Disability	Short Term Disability	Vision
1994						
1995						
1996						
1997						
1998						
1999						
2000						
2001						
2002						
2003						
2004						
2005						

If you require additional space, attach extra copies of Part IV in the same format as above. Sign and print your name on each additional page.



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 P.O. Box 24749, West Palm Beach, FL 33416

**PART V**

*All employers filing employee benefits claims must check one of the two boxes:*

I have posted notice to my employees that they may be eligible to make claims under this Settlement and informing them how to do so.

**OR**

The entity that purchased the eligible employee benefits policies listed on this claim form is no longer in business.

**PART VI – CERTIFICATION:**

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: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Print Name and Title: \_\_\_\_\_

Date: \_\_\_\_\_

**ENDNOTES**

<sup>1</sup>The “Gallagher Entities” are: AJG Canada ULC; AJG Capital, Inc.; AJG Chem Mod Holdings LLC; AJG Coal, Inc.; AJG Coal Indiana LLC; AJG Financial Services, Inc.; AJG Investments, Inc.; AJG North America ULC; AJG Two Pierce, Inc. (Delaware); Artex Insurance Company Ltd; Artex Risk Solutions, Inc.; Artex Underwriting Managers Ltd.; Arthur J. Gallagher; Arthur J. Gallagher & Co.; Arthur J. Gallagher & Co. (Bermuda) Limited; Arthur J. Gallagher & Co. (Canada) Ltd.; Arthur J. Gallagher & Co. (Florida); Arthur J. Gallagher & Co. (Illinois); Arthur J. Gallagher & Co. – Greenville; Arthur J. Gallagher & Co. – Little Rock; Arthur J. Gallagher & Co. Insurance Brokers of California, Inc.; Arthur J. Gallagher & Co. of Kentucky, Inc.; Arthur J. Gallagher & Co. of Mississippi, Inc.; Arthur J. Gallagher & Co. of New York, Inc.; Arthur J. Gallagher & Co. of Tennessee, Inc.; Arthur J. Gallagher Brokerage and Risk Management Services, LLC; Arthur J. Gallagher Intermediaries (Bermuda) Limited; Arthur J. Gallagher Management (Bermuda) Limited; Arthur J. Gallagher Risk Management Services, Inc.; Arthur J. Gallagher Service Co. (Delaware); Arthur J. Gallagher (UK) Limited; Arthur J. Gallagher Middle East BSC(c); Arthur J. Gallagher Asia Pte Ltd.; Arthur J. Gallagher Asia Limited; Arthur J. Gallagher (L) BHD; Arthur J. Gallagher Australasia Holdings Pty. Ltd.; Arthur J. Gallagher Reinsurance Australasia Pty Ltd.; Arthur J. Gallagher (Aus) Pty Ltd.; Australis Group (Underwriting) Pty Ltd.; Aviacargo Leasing Limited; Charity First Insurance Services, Inc.; C.W. Excess, Inc.; Commonwealth Premium Finance Corporation; Connor Hale Kerlake Limited; Edwin M. Rollins Company; Gallagher Bassett Services, Inc. (Delaware); Gallagher Bassett of New York, Inc.; Gallagher Bassett International Ltd. (UK); Gallagher Bassett Canada Inc.; Gallagher Bassett Services Pty Ltd; Gallagher Bassett International S.A.; Gallagher Benefit Services, Inc.; Gallagher Captive Services (Cayman) Limited; Gallagher Healthcare Insurance Services, Inc.; Gallagher Healthcare Insurance Services of Kansas City, LLC; Gallagher Holdings Bermuda Company Limited; Gallagher Holdings (UK) Limited Gallagher Lambert Group; Gallagher Loss Control Services, Inc.; Gallagher Re, Inc.; Gallagher Re Limited; GBS Administrators, Inc.; GBS Insurance and Financial Services, Inc.; GBS Retirement Services, Inc.; Interpacific Underwriting Agencies Pty Ltd.; Lamberson Koster & Co.; Manning & Smith Insurance, Inc.; MRS Holdings Limited; Morgan Read & Sharman Limited; Protected Insurance Company; Risk Management Partners Ltd.; Risk Placement Services, Inc. (Illinois); Risk Placement Services of Arizona, Inc.; Risk Placement Services of Arkansas, Inc.; Risk Placement Services of Louisiana, Inc.; Risk Placement Services of Massachusetts, Inc.; Risk Placement Services of Nevada, Inc.; Risk Placement Services of New York, Inc.; Risk Placement Services of Pennsylvania, Inc.; Risk Placement Services of Texas, Inc.; Scholastic Risk Services Limited; Sobieski & Bradley of Nevada, Inc.; Strand Underwriting Limited; Western Litigation, Inc.; and Wyatt Gallagher Bassett Workers Compensation Victoria Pty Ltd.

<sup>2</sup>“Commercial Broker Defendants” are: Marsh & McLennan Companies, Inc.; Marsh Inc.; Marsh USA, Inc.; Marsh USA Inc. (Connecticut); Seabury & Smith, Inc.; Aon Corporation; Aon Broker Services, Inc.; Aon Risk Services Companies, Inc.; Aon Risk Services, Inc. U.S.; Aon Risk Services Inc. of Maryland; Aon Risk Services, Inc. of Louisiana; Aon Risk Services of Texas, Inc.; Aon Risk Services, Inc. of Michigan; Aon Group, Inc.; Aon Services Group, Inc.; Aon Re, Inc.; Affinity Insurance Services, Inc.; Aon Re Worldwide, Inc.; Willis Group Holdings Limited; Willis Group Limited; Willis North America, Inc.; Willis of New York, Inc.; Willis Re Inc.; Stewart Smith Group; Wells Fargo & Company; Acordia, Inc.; Brown & Brown, Inc.; Hilb Rogal & Hobbs Company; BB&T Corporation; Branch Banking and Trust Company; BB&T Insurance Services, Inc.; Hub International Limited; U.S.I. Holdings Corporation; USI Insurance Services of Florida, Inc. (d/b/a USI Florida); Summit Global Partners of Florida, Inc. and any other broker that is added as a defendant in the Action prior to the time that the Notice is mailed.

<sup>3</sup>EB Broker Defendants” are: Acordia, Inc.; Aon Corporation; Aon Consulting Inc.; Aon Broker Services, Inc.; Aon Risk Services Companies, Inc.; Aon Risk Services Inc. U.S.; Aon Group, Inc.; Aon Services Group, Inc.; Aon Re, Inc.; BB&T Corporation; BB&T Insurance Services, Inc.; Benefits Commerce; Brown & Brown, Inc.; Brown & Brown Insurance Benefits, Inc.; Frank F. Haack & Associates; Hilb Rogal & Hobbs Company; Hub International Limited; Marsh & McLennan Companies, Inc.; Marsh Inc.; Marsh USA, Inc.; Mercer, Inc.; Mercer Human Resource Consulting LLC; Mercer Human Resource Consulting of Texas, Inc.; O’Neill, Finnegan & Jordan Insurance Agency, Inc.; Seabury & Smith, Inc.; Talbot Financial Corporation; Universal Life Resources; ULR Insurance Services, Inc.; USI Holdings Corporation; USI Consulting Group; USI Insurance Services Corporation; Wells Fargo & Company; Willis Group Holdings Limited; and Willis North America, Inc.



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