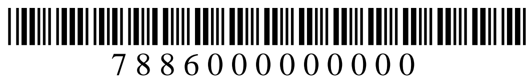
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Griffin, et al. v. Benefytt Technologies, Inc. et al.
U.S. District Court
Southern District of Florida (Case No. 20- cv-62371-AHS)

CLAIM FORM

SAVE TIME BY SUBMITTING YOUR CLAIM ONLINE AT WWW.BENEFYTTSETTLEMENT.COM

YOUR CLAIM FORM MUST BE SUBMITTED ON OR BEFORE APRIL 15, 2024	Griffin v. Benefytt c/o Kroll Settlement Administration PO Box 5324 New York, NY 10150-5324	FOR OFFICE USE ONLY

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GENERAL CLAIM FORM INFORMATION

All capitalized terms not otherwise defined herein shall have the same meanings ascribed to them in the Settlement Agreement, which can be downloaded at www.benefyttsettlement.com.

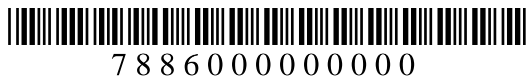
To recover as a Settlement Class Member based on your claims in the above-captioned class action lawsuit (the "Action"), and/or to recover as a member of the Medical Expense Subclass in this Action, you must complete and sign this Claim Form. If you fail to submit a properly completed Claim Form, then you will be precluded from any recovery in connection with the proposed Settlement. And if you fail to submit a properly completed Claim Form and fail to request exclusion from the Settlement as set forth in the accompanying "Important Notice About a Proposed Class Action Settlement That Affects You" (the "Class Notice"), then you will also have released your claims against Defendants in this Action.

YOU MUST SUBMIT ONLINE AT WWW.BENEFYTTSETTLEMENT.COM OR MAIL YOUR COMPLETED AND SIGNED CLAIM FORM SO THAT IT IS POSTMARKED NO LATER THAN APRIL 15, 2024, TO THE SETTLEMENT ADMINISTRATOR ADDRESSED AS FOLLOWS:

Griffin v. Benefytt
c/o Kroll Settlement Administration
PO Box 5324
New York, NY 10150-5324

TO SUBMIT A CLAIM FOR PAYMENT:

1. Please fill out and sign Parts 1 and 3 below in its entirety and sign where indicated.
2. Please fill out Part 2 below in its entirety if you are a member of the Medical Expense Subclass and sign where indicated.
3. If submitting via mail, keep a copy of your Claim Form for your records.
4. If you desire an acknowledgment that the Settlement Administrator received your Claim Form, please send it by Certified U.S. Mail, Return Receipt Requested.
5. If you submit your Claim Form electronically, your submission is not deemed to have been properly submitted unless the Settlement Administrator sends you confirmation of receipt of the electronically submitted Claim Form.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If you move, please send your new address to the Settlement Administrator at the address below.

AGAIN, THIS CLAIM FORM MUST BE RECIVED (IF SUBMITTED ONLINE) OR POSTMARKED (IF MAILED) NO LATER THAN APRIL 15, 2024 ADDRESSED AS FOLLOWS:

Griffin v Benefytt
c/o Kroll Settlement Administration,
PO Box 5324
New York, NY 10150-5324

To submit your claim online visit www.benefyttsettlement.com

I. THE SETTLEMENT CLASSES

The American National Class. All individuals who purchased Benefytt's limited benefit indemnity plans or short term medical plans through American National from May 5, 2016 through December 1, 2023, and paid fees and/or premiums that were not completely recovered through a refund or chargeback.
Assurance Class. All individuals who purchased Benefytt's limited benefit indemnity plans or short term medical plans through Assurance from May 5, 2016 through December 1, 2023, and paid fees and/or premiums that were not completely recovered through a refund or chargeback.
The Benefytt Class. All individuals who purchased limited benefit indemnity plans or short term medical plans directly from Benefytt from May 5, 2016 through December 1, 2023, and paid fees and/or premiums that were not completely recovered through a refund or chargeback.
The Priority Insurance Class. All individuals who purchased Benefytt's limited benefit indemnity plans or short term medical plans through Priority Insurance from May 5, 2016 through December 1, 2023, and paid fees and/or premiums that were not completely recovered through a refund or chargeback.
The Medical Expense Subclass. All individuals within any of the above Classes who incurred uncovered medical expense(s).

If you complete this Claim Form properly and you timely submit it to the Settlement Administrator, then you will receive a cash settlement related to the premiums and fees you paid for the Benefytt limited benefit indemnity plans and/or short term medical plans you purchased through Benefytt, Assurance, American National and/or Priority Assurance. The amount you will receive cannot be determined until all Claim Forms are received.

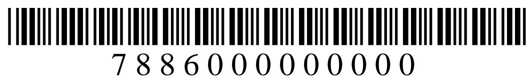
II. THE MEDICAL EXPENSE SUBCLASS

In addition to being a member of the American National Class, the Assurance Class, the Benefytt Class and/or the Priority Insurance Class, you may also be a member of the Medical Expense Subclass, which includes all individuals within these Classes who incurred uncovered medical expenses.

You incurred "Uncovered Medical Expense(s)" if you (i) incurred medical expenses (ii) from May 5, 2016, through December 1, 2023 (iii) for which you made a claim for reimbursement that (iv) was rejected in whole or in part.

If you complete the "Medical Expense Subclass" portion of this Claim Form properly and you timely submit it to the Settlement Administrator, then you will receive an enhanced cash settlement. Again, the amount you will receive cannot be determined until all Claim Forms are received.

If you believe you are not a member of the Medical Expense Subclass, then do not complete the "Medical Expense Subclass" portion of this Claim Form. (You will still be eligible to receive a cash settlement as part of the main Settlement Classes, as described in Section I above.)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This Claim Form Must Be Postmarked (if Mailed) or Received (if Submitted Online) No Later Than:

April 15, 2024

Please Type or Print (in Blue or Black Ink)

PART 1: CLAIMANT IDENTIFICATION

*Class Member ID: **7 8 8 6 0** ____ ____ ____ ____ ____ ____ ____ ____

*Class Member ID: Your Class Member ID can be found on the Postcard Notice you received informing you about this Settlement. If you need additional help locating this Class Member ID, please contact the Settlement Administrator at (833) 383-5268.

______________________________________ ____ ____

First Name MI Last Name

____

Name of executor, administrator, guardian Conservator and/or trustee (if applicable) | TITLE | Statement of authority to act for Claimant.

(In the case of a Death: We require a copy of the Death Certificate along with a will, Probate judgement, etc. and a copy of your State/Federal Identification showing the name and current address of all the legally entitled heirs. Please mail any documentation to the Settlement Administrator)

(_____ _____ _____) _____ _____ _____ - _____ _____ _____ _____

Telephone Number (Primary Daytime)

(_____ _____ _____) _____ _____ _____ - _____ _____ _____ _____

Telephone Number (Alternate)

____@____________________________________

E-mail Address

____

Address 1

____

Address 2

____ _____ _____ _____ _____ _____ _____ _____

City State Zip Code

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PART 2: MEDICAL EXPENSE SUBCLASS CLAIM

Please read and sign below if the following is true and correct.

I swear and affirm under penalty of perjury that all of the following is true and correct:

1. I incurred one or more medical expenses from May 5, 2016 to December 1, 2023;
2. I made a claim or claims for reimbursement of those medical expenses under a Benefytt limited benefit indemnity plan or short term medical plan purchased through American National, Assurance, Beneytt and/or Priority Insurance that was in effect at the time the medical expense was incurred; and
3. My claim or claims for coverage was or were rejected in whole or in part.
4. As a result of this claim or these claims being rejected in whole or in part, my medical expenses not reimbursed by coverage total (check one):

______ $25,000.00 or less;

______ between $25,000.00 and $50,000.00; or

______ greater than $50,000.00.

Sign Name Here: ____

Print Name Here: ____

PART 3: FINAL SIGNATURE AND AFFIRMATION

I declare under penalty of perjury under the laws of the United States of America that all the foregoing information supplied by me in this Claim Form is true and correct.

Signed this ______________________ day of ______________ (Month/Year)

in ____

(City), (State/Country)

____
(Sign your name here)

____
(Type or print your name here)

____
(If not you personally, state the capacity of person(s) signing, *e.g.*, Beneficial Holder, Executor or Administrator)

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