

Section III – Confirmation of Class Membership

Telephone Number(s) for which you were the regular user or subscriber during **April 7, 2018, through March 20, 2023**, at which you received one or more calls promoting Health Insurance Associates LLC:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Section IV – Required Affirmations

I agree that, by submitting this Claim Form, the information in this Claim Form is true and correct to the best of my knowledge. I understand that my Claim Form may be subject to audit, verification, and Court review. I am aware that I can obtain a copy of the full notice and Settlement Agreement at www. InsuranceTCPASettlement.com or by writing the Settlement Administrator at the email address info@InsuranceTCPASettlement.com or the postal address *Insurance TCPA Settlement, c/o A.B. Data, Ltd., P.O. Box 173039, Milwaukee, WI 53217.*

Dated: _____

Signature: _____

SETTLEMENT ADMINISTRATOR ADDRESS (where to send the completed form if submitting by mail):

*Insurance TCPA Settlement
c/o A.B. Data, Ltd.
P.O. Box 173039
Milwaukee, WI 53217*