# ALFA VISION INSURANCE CORPORATION PROOF OF CLAIM

**Must be Postmarked No Later Than November 15, 2017**

Please provide all the requested and available information and mail this form in an envelope addressed to: **ALFA Class Settlement Administrator, P.O. Box 2887, Brentwood, TN 37024-2887.** The claim must be postmarked no later than November 15, 2017.

If you are an Arkansas resident during the time period from August 8, 2009 through September 1, 2014, and an ALFA Vision Insurance Corporation named insured, who reported a loss (made a claim), and whose claim was denied due to policy cancellation for non-payment of premiums by a cancellation notice issued prior to a default in payment, you are entitled to make a claim for a covered incident under your ALFA Vision insurance policy in an amount up to $1,000.

## Insured Contact Information

Please provide the name and current address of the ALFA named insured, whose vehicle was damaged or in an accident.

Insured Name:_____
(last) (first) (middle)

Current Address:_____
(street)

_____
(city) (state) (zip)

Telephone:_____

E-Mail Address:_____

## Accident Information

Date of Accident:_____

Insured's Vehicle Description:_____

Insured's VIN:_____

ALFA Insurance Policy Number:_____

ALFA Claim No. _____

## CLAIM VERIFICATION

The above information is true and correct to the best of my knowledge and belief.

_____ Dated:_____
Signature of ALFA Insured