

**MUST BE  
POSTMARKED ON  
OR BEFORE  
MAY 3, 2010**

**SBLI Litigation Settlement Fund  
c/o Settlement Administrator  
The Garden City Group, Inc.  
P.O. Box 9472  
Dublin, OH 43017-4572  
Toll-Free: 1 (800) 254-7328**



**CLAIM BY AFFIDAVIT FOR A BENEFICIARY(IES) AND HEIR(S)  
OR  
ADDRESS CORRECTIONS**

If you are the beneficiary or heir of a person who owned a life insurance Policy from the Savings Bank Life Insurance Company of Massachusetts ("SBLI") on (1) January 1, 1992 and/or (2) a Policy that was in force on at least one of December 31, 2000 or December 31, 2001 or December 31, 2002, and was entitled to a dividend for at least one of those years, then you may be entitled to payment resulting from the settlement of the lawsuit captioned *Goldstein et al. v. Savings Bank Life Insurance Company of Massachusetts* (Mass. Superior Court, Civ. Action No. 98-2330-BLS1). PLEASE NOTE THAT AN HEIR MAY ONLY RECEIVE PAYMENT THROUGH THE SETTLEMENT WHERE THERE IS NO KNOWN LIVING BENEFICIARY WHO MAKES A TIMELY CLAIM.

To make a claim, please complete and submit this Affidavit so that The Garden City Group, Inc., the Court-appointed Settlement Administrator listed above, can determine whether you are eligible for any settlement payment. Your form must be postmarked no later than May 3, 2010 to the address above.

If you do not send in a signed, completed copy of this Affidavit of Beneficiary or Heir to the above address postmarked by the deadline, then your claim will be rejected without further consideration and you will not receive any payment in connection with the settlement of this litigation. Do not send your claim to the Court or to any other address.

**Affidavit of Beneficiary or Heir  
(Please complete one Affidavit for each applicable Policy)**

Check here if you are using this form solely to correct your address.

My name is \_\_\_\_\_, and I am the Beneficiary OR Heir (circle one)  
of a deceased policy holder [insert full name of the insured] \_\_\_\_\_.

My relationship to the deceased policyholder was \_\_\_\_\_.

I declare that the above named deceased policyholder owned a Savings Bank Life Insurance Company of Massachusetts policy on at least one of the following dates (check all that apply, if known):

- January 1, 1992       December 31, 2000       December 31, 2001       December 31, 2002

Please provide the SBLI Policy Number(s) if known: \_\_\_\_\_

**My current contact information is:**

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Daytime Phone:** (        ) \_\_\_\_\_ **Evening Phone:** (        ) \_\_\_\_\_



The last known address of the deceased policyholder was:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The decedent passed away on or around: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.  
MM DD YYYY

I have read and understand the Class Notice (available at [www.SBLISETTLEMENT.com](http://www.SBLISETTLEMENT.com)) and I believe that the SBLI Policy or Policies on which I am the beneficiary is in the Class, or there is no known living beneficiary and I am the heir to the deceased policyholder of such a Policy(ies), and that I am therefore entitled to a share of the Net Settlement Fund.

I understand that the information that I provide in this Affidavit is subject to verification, and I agree to cooperate with verification efforts by the Administrator, Plaintiffs' Class Counsel or the Court. I understand that this information will be used solely to determine my eligibility for a claim and the amount of my claim and any payment. I understand that if my claim is likely to exceed \$150 that I will be required by the Administrator to complete a Proof of Claim Form which the Administrator will send to me with further instructions. Please note that there will only be one Payee per policy.

I consent to the jurisdiction of the Massachusetts Suffolk Superior Court with respect to any and all questions concerning the validity of this Affidavit. I understand that no one has offered me tax advice about the tax consequences of any payment or benefits received in connection with my claim and that it is my responsibility to determine any such consequences.

I declare under the penalties of perjury that the foregoing is true and correct and I certify that all of the information I provided on this Affidavit of Beneficiary or Heir is true, complete and accurate to the best of my knowledge.

\_\_\_\_\_  
Signature Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YYYY

**THIS AFFIDAVIT DOES NOT REQUIRE A NOTARY**