



Dear Claimant

The Florida Department of Financial Services has assisted Holocaust victims, Survivors, and their families, in the filing and payment of unpaid Holocaust era insurance claims at no cost to claimants since 1998. To date Florida residents have received offers totaling over \$13,024,000 from European insurance companies and the German Foundation.

The International Commission on Holocaust Era Insurance Claims ("ICHEIC") was formed in 1998 by the National Association of Insurance Commissioners ("NAIC"), European insurance companies, European trade organizations, Jewish organizations and the State of Israel. Working together with insurance companies and partner entities throughout Europe, ICHEIC identified, settled, and paid over \$306 million dollars to Survivors of the Holocaust and their heirs. ICHEIC officially closed on March 30, 2007.

At ICHEIC's concluding meeting, every company that was a member of the commission, the SJOA Foundation, as well as companies of the German Insurance Association, through its partnership agreement with ICHEIC, reaffirmed their commitment to continue to review and process claims sent directly to them.

Anyone with reason to believe that an insurance policy belonging to them or to a relative that remains unpaid may submit an insurance claim to the Florida Department of Financial Services. The claim form is designed to assist you in providing the information needed to carry out archival research and to ensure that companies have as much information as possible.

The Florida Department of Financial Services has a cooperative agreement with the Holocaust Claims Processing Office in New York to process claims by Florida residents. We will coordinate the filing of claims and assist HCPO and Florida claimants in the claims process.

Please fill out this claim form as completely as possible. You should complete this claim form by typing or printing clearly in block capital letters. In order for this office and HCPO to receive correspondence about your claim you must sign the Declaration of Consent on page 14 of the claim form.

Please submit this claim form along with any copies of any supporting documents to the address included on the top of the enclosed Insurance Claim Form Instruction Sheet. Call Lynn Grossman at 1-800-388-4069 if you need assistance.

Sincerely,
Lynn Grossman

FLORIDA DEPARTMENT OF FINANCIAL SERVICES
Lynn Grossman • Holocaust Claims Coordinator
Division of Legal Services
200 E. Gaines St. • Tallahassee, FL 32399-4205 • Tel. 850-413-4160 • Fax 850-488-6129
Email • Lynn.Grossman@myfloridacfo.com
Affirmative Action • Equal Opportunity Employer

PART 1: CLAIMANT INFORMATION

I. PERSONAL INFORMATION

INFORMATION ABOUT YOURSELF. PLEASE INCLUDE A COPY OF YOUR IDENTIFICATION. DO NOT SEND THE ORIGINAL.

LAST NAME _____

FIRST NAME _____

MIDDLE NAME(S) _____

MAIDEN NAME _____

NAME CHANGES (INCLUDING CHANGES OF SPELLING) _____

CURRENT ADDRESS (PLEASE INCLUDE COUNTRY AND AREA CODES FOR TELEPHONE AND FAX NUMBERS):

STREET _____

APT./UNIT No. _____

CITY _____

STATE _____

ZIP/POSTAL CODE _____

COUNTRY _____

TELEPHONE _____

MOBILE PHONE _____

FAX _____

EMAIL _____

DATE OF BIRTH (MONTH/DAY/YEAR) _____

PLACE OF BIRTH (CITY/STATE/COUNTRY) _____

PREVIOUS PLACES OF RESIDENCE UP TO AND INCLUDING MAY 1945 (IF OUTSIDE THE U.S.)

FATHER'S NAME

FIRST NAME _____

MIDDLE NAME(S) _____

LAST NAME _____

MOTHER'S NAME

FIRST NAME _____

MIDDLE NAME(S) _____

LAST NAME _____

MAIDEN NAME _____

II. ALTERNATE CONTACT

IN THE EVENT THAT THE HCPO IS UNABLE TO REACH YOU, PLEASE PROVIDE DETAILS REGARDING SOMEONE ELSE WE COULD CONTACT. THE HCPO WILL NOT CONSIDER THIS PERSON AS YOUR LEGAL OR OTHER REPRESENTATIVE AND WILL NOT PROVIDE THIS PERSON WITH ANY DOCUMENTATION RELATING TO YOUR CLAIM, UNLESS YOU IDENTIFY THIS CONTACT PERSON AS YOUR LEGAL OR OTHER REPRESENTATIVE IN PART 1, SECTION IV OF THIS FORM.

NAME _____
RELATIONSHIP TO YOU _____
STREET _____
APT./UNIT No. _____
CITY _____
STATE _____
ZIP/POSTAL CODE _____
COUNTRY _____
TELEPHONE _____ MOBILE PHONE _____
FAX _____ EMAIL _____

III. CLAIMANT REPRESENTATIVE INFORMATION (WHEN APPLICABLE)

WHERE THE PERSON SUBMITTING THE CLAIM IS A REPRESENTATIVE OF THE CLAIMANT AND NOT SOMEONE ENTITLED TO INHERIT THE POLICY'S PROCEEDS, THIS SECTION MUST BE FILLED OUT. WRITTEN AND NOTARIZED AUTHORIZATION OR A POWER OF ATTORNEY FROM THE CLAIMANT PROVIDING AUTHORIZATION TO THE NAMED REPRESENTATIVE MUST BE INCLUDED. ALL INFORMATION REGARDING THE CLAIMANT (THE INDIVIDUAL WHO HAS GRANTED THE POWER OF ATTORNEY OR OTHER AUTHORIZATION) MUST STILL BE PROVIDED IN PART 1 OF THIS FORM.

REPRESENTATIVE'S LAST NAME _____
REPRESENTATIVE'S FIRST NAME _____
REPRESENTATIVE'S MIDDLE NAME _____
DO YOU HAVE DOCUMENTATION CONFIRMING THIS RELATIONSHIP? YES (PLEASE INCLUDE A COPY WITH THIS FORM) No
REPRESENTATIVE'S ADDRESS _____
LAW FIRM, COMPANY, OR OTHER _____
STREET _____
APT./UNIT No. _____
CITY _____
STATE _____
ZIP/POSTAL CODE _____
COUNTRY _____
TELEPHONE _____ MOBILE PHONE _____
FAX _____ EMAIL _____

IV. OTHER HEIRS OF THE POLICY HOLDER

PLEASE INDICATE BELOW THE NAMES OF OTHER HEIRS TO THE CLAIMED POLICY(IES).

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____
RELATIONSHIP TO YOU _____
STREET _____
APT./UNIT No. _____
CITY _____
STATE _____
ZIP/POSTAL CODE _____
COUNTRY _____
TELEPHONE _____ MOBILE PHONE _____
FAX _____ EMAIL _____

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____
RELATIONSHIP TO YOU _____
STREET _____
APT./UNIT No. _____
CITY _____
STATE _____
ZIP/POSTAL CODE _____
COUNTRY _____
TELEPHONE _____ MOBILE PHONE _____
FAX _____ EMAIL _____

FIRST NAME _____ MIDDLE NAME _____ LAST NAME _____
RELATIONSHIP TO YOU _____
STREET _____
APT./UNIT No. _____
CITY _____
STATE _____
ZIP/POSTAL CODE _____
COUNTRY _____
TELEPHONE _____ MOBILE PHONE _____
FAX _____ EMAIL _____

V. PREVIOUS CLAIMS MADE FOR HOLOCAUST-ERA INSURANCE POLICIES

PLEASE INDICATE IF YOU OR ANY OF YOUR FAMILY MEMBERS HAVE MADE ANY PREVIOUS CLAIMS TO ANY ORGANIZATION OR INSURANCE COMPANY FOR A HOLOCAUST-ERA INSURANCE POLICY. CHECK ALL THAT APPLY.

- ASSICURAZIONI GENERALI S.P.A. - POLICY INFORMATION CENTER ("PIC") AND/OR THE GENERALI TRUST FUND ("GTF")
NAME OF POLICYHOLDER(S) _____
CLAIM NUMBER(S) _____

- AUSTRIAN GENERAL SETTLEMENT FUND ("GSF")
NAME OF POLICYHOLDER(S) _____

- CLAIMS RESOLUTION TRIBUNAL ("CRT")
NAME OF POLICYHOLDER(S) _____
CLAIM NUMBER(S) _____

- DIRECTLY TO A EUROPEAN INSURANCE COMPANY
NAME OF COMPANY(IES) _____
NAME OF POLICYHOLDER(S) _____
CLAIM NUMBER(S) _____

- HOLOCAUST FOUNDATION FOR INDIVIDUAL INSURANCE CLAIMS ("SJOA FOUNDATION")
NAME OF POLICYHOLDER(S) _____
CLAIM NUMBER(S) _____

- INTERNATIONAL COMMISSION ON HOLOCAUST ERA INSURANCE CLAIMS ("ICHEIC")
NAME OF POLICYHOLDER(S) _____
CLAIM NUMBER(S) _____

VI. PREVIOUS COMPENSATION

HAVE YOU OR ANYBODY ELSE PARTICIPATED IN ANY COMPENSATION/RESTITUTION PROCEDURE FOR THIS CLAIM? E.G., DEUTSCHE WIEDERGUTMACHUNG BUNDESENTSCHÄDIGUNGSGESETZ (BEG), BUNDESRÜCKERSTATTUNGSGESETZ (BRÜG), LASTENSAUSGLEICHSGESETZ (LAG), US FOREIGN CLAIMS SETTLEMENT COMMISSION OR OTHER (SEE SECTION III ABOVE).

Yes No

IF YES, UNDER WHICH COMPENSATION SCHEME?

IF NO APPLICATION WAS MADE, WHY NOT?

IF YOU APPLIED, BUT NO PAYMENT WAS RECEIVED, WHY NOT?

PART 2: POLICYHOLDER

THIS SECTION REQUESTS ALL INFORMATION KNOWN ABOUT THE PERSON WHO PURCHASED THE POLICY(IES). THIS INDIVIDUAL IS REFERRED TO AS THE "POLICYHOLDER".

LAST NAME _____
FIRST NAME _____
MIDDLE NAME(S) _____
MAIDEN NAME _____
ANY OTHER NAME(S) USED BY THE POLICYHOLDER _____

CITIZENSHIP/ NATIONALITY _____
DATE OF BIRTH (MONTH/DAY/YEAR) _____
PLACE OF BIRTH (CITY/STATE/COUNTRY) _____
DATE OF DEATH (MONTH/DAY/YEAR) _____
PLACE OF DEATH (CITY/STATE/COUNTRY) _____
FULL NAME OF POLICYHOLDER'S FATHER _____
FULL NAME OF POLICYHOLDER'S MOTHER
PLEASE INCLUDE MAIDEN NAME _____

FULL NAME OF POLICYHOLDER'S SPOUSE
PLEASE INCLUDE MAIDEN NAME IF APPLICABLE _____
DATE OF MARRIAGE (MONTH/DAY/YEAR) _____
PLACE OF MARRIAGE
(CITY/STATE/COUNTRY) _____

NAMES OF ANY BUSINESS OWNED BY THE POLICYHOLDER _____
LOCATION OF ANY BUSINESS OWNED BY THE POLICYHOLDER
(CITY/STATE/COUNTRY) _____

ALL KNOWN PLACES OF RESIDENCE UP TO AND INCLUDING MAY 1945 (IF OUTSIDE THE U.S.)

CLAIMANT'S RELATIONSHIP TO THE POLICYHOLDER _____
DO YOU HAVE DOCUMENTATION CONFIRMING THIS RELATIONSHIP? YES NO
IF SO, PLEASE DESCRIBE AND INCLUDE A COPY WITH YOUR COMPLETED CLAIM FORM.

PART 3: INSURED

THIS SECTION REQUESTS ALL INFORMATION KNOWN ABOUT THE PERSON WHO WAS COVERED BY THE POLICY(IES). THIS INDIVIDUAL IS REFERRED TO AS THE "INSURED."

- CLAIMANT IS THE INSURED. DO NOT COMPLETE THIS SECTION
- POLICYHOLDER IS THE INSURED. DO NOT COMPLETE THIS SECTION.
- INSURED IS THE POLICYHOLDER'S SPOUSE.
- INSURED IS THE POLICYHOLDER'S CHILD.

LAST NAME

FIRST NAME

MIDDLE NAME(S)

MAIDEN NAME

ANY OTHER NAME(S) USED BY THE INSURED

CITIZENSHIP/ NATIONALITY

DATE OF BIRTH (MONTH/DAY/YEAR)

PLACE OF BIRTH (CITY/STATE/COUNTRY)

DATE OF DEATH (MONTH/DAY/YEAR)

PLACE OF DEATH (CITY/STATE/COUNTRY)

FULL NAME OF INSURED'S FATHER

FULL NAME OF INSURED'S MOTHER

PLEASE INCLUDE MAIDEN NAME

FULL NAME OF INSURED'S SPOUSE

PLEASE INCLUDE MAIDEN NAME IF APPLICABLE

DATE OF MARRIAGE (MONTH/DAY/YEAR)

PLACE OF MARRIAGE
(CITY/STATE/COUNTRY)

ALL KNOWN PLACES OF RESIDENCE UP TO AND INCLUDING MAY 1945 (IF OUTSIDE THE U.S.)

CLAIMANT'S RELATIONSHIP TO THE INSURED

DO YOU HAVE DOCUMENTATION CONFIRMING THIS RELATIONSHIP?

YES NO

IF SO, PLEASE DESCRIBE AND INCLUDE A COPY WITH YOUR COMPLETED CLAIM FORM.

PART 4: BENEFICIARY

THIS SECTION REQUESTS ALL INFORMATION KNOWN ABOUT THE PERSON NAMED TO RECEIVE PROCEEDS OR BENEFITS OF THE INSURANCE POLICY. THIS PERSON IS REFERRED TO AS THE "BENEFICIARY."

- CLAIMANT IS THE BENEFICIARY. *DO NOT COMPLETE THIS SECTION* BENEFICIARY IS THE POLICYHOLDER'S SPOUSE.
 POLICYHOLDER IS THE BENEFICIARY. *DO NOT COMPLETE THIS SECTION.* BENEFICIARY IS THE POLICYHOLDER'S CHILD.

LAST NAME _____

FIRST NAME _____

MIDDLE NAME(S) _____

MAIDEN NAME _____

ANY OTHER NAME(S) USED BY THE
BENEFICIARY _____

CITIZENSHIP/ NATIONALITY _____

DATE OF BIRTH (MONTH/DAY/YEAR) _____

PLACE OF BIRTH (CITY/STATE/COUNTRY) _____

DATE OF DEATH (MONTH/DAY/YEAR) _____

PLACE OF DEATH (CITY/STATE/COUNTRY) _____

FULL NAME OF BENEFICIARY'S FATHER _____

FULL NAME OF BENEFICIARY'S MOTHER _____

PLEASE INCLUDE MAIDEN NAME _____

FULL NAME OF BENEFICIARY'S SPOUSE _____

PLEASE INCLUDE MAIDEN NAME IF APPLICABLE _____

DATE OF MARRIAGE (MONTH/DAY/YEAR) _____

PLACE OF MARRIAGE
(CITY/STATE/COUNTRY) _____

ALL KNOWN PLACES OF RESIDENCE UP TO AND INCLUDING MAY 1945 (IF OUTSIDE THE U.S.)

CLAIMANT'S RELATIONSHIP TO THE BENEFICIARY _____

DO YOU HAVE DOCUMENTATION CONFIRMING THIS RELATIONSHIP? YES NO

IF SO, PLEASE DESCRIBE AND INCLUDE A COPY WITH YOUR COMPLETED CLAIM FORM.

PART 5: CHILDREN OF THE POLICYHOLDER

THIS SECTION SEEKS INFORMATION ABOUT BIOLOGICAL AND LAWFULLY ADOPTED CHILDREN OF THE POLICYHOLDER, OTHER THAN THE CLAIMANT SHOULD THE CLAIMANT BE A CHILD OF THE POLICYHOLDER. PLEASE INCLUDE ADDITIONAL PAGES AS NEEDED.

CLAIMANT IS A CHILD OF THE POLICYHOLDER. *DO NOT COMPLETE THIS SECTION.*

CHILD No. 1 (OTHER THAN CLAIMANT)

BIOLOGICAL ADOPTED (PLEASE CHECK ONE)

LAST NAME _____
FIRST NAME _____
MIDDLE NAME(S) _____
MAIDEN NAME (IF APPLICABLE) _____
NATIONALITY _____
DATE OF BIRTH (MONTH/DAY/YEAR) _____
PLACE OF BIRTH (CITY/STATE/COUNTRY) _____
DATE OF DEATH (MONTH/DAY/YEAR) _____
PLACE OF DEATH (CITY/STATE/COUNTRY) _____
FATHER'S NAME _____
MOTHER'S NAME: _____

CHILD No. 2 (OTHER THAN CLAIMANT)

BIOLOGICAL ADOPTED (PLEASE CHECK ONE)

LAST NAME _____
FIRST NAME _____
MIDDLE NAME(S) _____
MAIDEN NAME (IF APPLICABLE) _____
NATIONALITY _____
DATE OF BIRTH (MONTH/DAY/YEAR) _____
PLACE OF BIRTH (CITY/STATE/COUNTRY) _____
DATE OF DEATH (MONTH/DAY/YEAR) _____
PLACE OF DEATH (CITY/STATE/COUNTRY) _____
FATHER'S NAME _____
MOTHER'S NAME _____

PART 6: WHICH INSURANCE COMPANY ISSUED THE POLICY?

NAME OF COMPANY _____

I DO NOT KNOW

PLACE WHERE INSURANCE POLICY WAS PURCHASED:

CITY _____

STATE _____

COUNTRY _____

OTHER INFORMATION WHICH MIGHT SUPPORT THE SEARCH.

FOR EXAMPLE: NAME OF INSURANCE AGENT OR INTERMEDIARY WHO SOLD THE POLICY/LETTERHEAD/CORPORATE LOGO.

PART 7: DOCUMENTS

PLEASE PROVIDE COPIES OF ANY DOCUMENTS, STATEMENTS OR OTHER INFORMATION SUPPORTING YOUR CLAIM.

I DO NOT HAVE DOCUMENTATION.

POLICY

PREMIUM PAYMENT RECEIPTS

CORRESPONDENCE

OTHER, PLEASE SPECIFY:

PART 8: INFORMATION ABOUT THE INSURANCE POLICY

FOR THOSE INDIVIDUALS WHO HAVE DETAILED INFORMATION, SUCH AS INSURANCE COMPANY NAME, POLICY NUMBERS, TYPE OF INSURANCE AND THE CITY WHERE THE POLICY WAS TAKE OUT, PLEASE PROVIDE SUCH INFORMATION BELOW. COPIES OF ALL SUPPORTING DOCUMENTATION SHOULD BE INCLUDED. DO NOT SEND ORIGINALS OF ANY DOCUMENTS.

TYPE OF INSURANCE POLICY

LIFE INSURANCE ENDOWMENT DOWRY OTHER, PLEASE SPECIFY: _____

POLICY NUMBER _____

CURRENCY _____

SUM INSURED _____

DATE OF ISSUE _____

DATE OF MATURITY _____

MODE OF PAYMENT OF THE PREMIUM SINGLE PAYMENT WEEKLY MONTHLY ANNUALLY

AMOUNT OF PREMIUM _____

TO THE BEST OF YOUR KNOWLEDGE WERE ALL PREMIUMS PAID? YES NO

IF NOT, FOR HOW LONG WERE PREMIUM PAYMENTS MADE? WHY WERE THE PAYMENTS STOPPED?

ARE YOU AWARE OF ANY PAYMENTS RESULTING OUT OF THE INSURANCE POLICY? YES NO

IF YES, PLEASE INDICATE WHEN PAYMENT WAS MADE, TO WHOM, AND FOR WHAT AMOUNT?

HAS ANYBODY APPROACHED THE INSURANCE COMPANY ABOUT THIS POLICY? YES NO

IF YES, PLEASE PROVIDE DETAILS AND INCLUDE COPIES OF ALL RELEVANT CORRESPONDENCE.

PART 9: FAMILY TREE

TO EXPLAIN THE FAMILY RELATIONSHIPS, PLEASE SKETCH A FAMILY TREE ON THE FAMILY FORM, WHICH IS ATTACHED TO THE CLAIM FORM, OR ON A SEPARATE SHEET OF PAPER.

IN ADDITION, PLEASE PROVIDE INFORMATION AND/OR COPIES OF ANY DOCUMENTS THAT WOULD SHOW THAT YOU ARE RELATED TO THE POLICYHOLDER, SUCH AS A PASSPORT OR OTHER IDENTIFYING DOCUMENTS: BIRTH CERTIFICATES, DEATH CERTIFICATES, MARRIAGE CERTIFICATE, AND CORRESPONDENCE WITH IDENTIFYING DETAILS. WHILE THE HCPO UNDERSTANDS THAT THERE ARE MANY REASONS WHY INFORMATION AND DOCUMENTATION ARE NOT AVAILABLE, YOU ARE URGED TO PROVIDE AS MUCH AS YOU HAVE.

PART 10: CLAIMS NOT BASED ON FAMILIAL RELATIONSHIPS

IF YOUR CLAIM IS NOT BASED ON A FAMILIAL RELATIONSHIP TO THE POLICYHOLDER, PLEASE EXPLAIN WHY YOU BELIEVE THAT YOU ARE ENTITLED TO THE POLICY.

IF POSSIBLE, PLEASE PROVIDE INFORMATION AND COPIES OF ANY TESTAMENTARY DOCUMENTS THAT MIGHT SHOW THAT YOU ARE ENTITLED TO THE POLICY, SUCH AS:

- WILLS
- TESTAMENTARY OR PROBATE DOCUMENTS
- CERTIFICATES OF INHERITANCE
- OTHER, PLEASE SPECIFY :

OTHER SUPPORTING INFORMATION REGARDING YOUR ENTITLEMENT TO THE POLICY.

PART 11: FURTHER INFORMATION

IS THE POLICYHOLDER NAME YOU INCLUDED UNDER PART 5 A POTENTIAL MATCH YOU FOUND ON THE LIST PUBLISHED ON ICHEIC'S POTENTIAL POLICYHOLDER LIST (WWW1.YADVASHEM.ORG/PHEIP)? YES NO

IF YES, PLEASE INCLUDE THE INFORMATION ABOUT THE POLICYHOLDER AS DESCRIBED ON THE LIST?

LAST NAME _____
FIRST NAME _____
LAST KNOWN RESIDENCE _____
BIRTH YEAR _____
WHERE POLICY WAS ISSUED _____
INSURANCE COMPANY _____

WHAT IS THE BASIS FOR YOUR CLAIM ON THE POLICY(IES) LISTED ABOVE?

FOR INDIVIDUALS WHO DO NOT HAVE THE SPECIFIC INFORMATION REQUESTED IN PARTS 5-9, PLEASE PROVIDE A SUMMARY FOR THE BASIS OF YOUR BELIEF THAT AN INSURANCE POLICY WAS NOT PAID BY A EUROPEAN INSURANCE COMPANY. DESCRIBE YOUR CONNECTION TO THIS POLICY AND WHY YOU FEEL YOU ARE ENTITLED TO THE PROCEEDS. PLEASE BE AS DETAILED AS POSSIBLE.

PLEASE ADD ANY OTHER INFORMATION WHICH MIGHT BE HELPFUL.

PART 12: DECLARATION OF CONSENT

BY SIGNING BELOW, I HEREBY AUTHORIZE THE FLORIDA DEPARTMENT OF FINANCIAL SERVICES ("DFS") AND THE HOLOCAUST CLAIMS PROCESSING OFFICE OF THE NEW YORK STATE BANKING DEPARTMENT ("HCPO") TO CONSULT AND DISCUSS WITH ANY AND ALL INSURANCE COMPANIES AND THEIR REPRESENTATIVES (INCLUDING MEMBERS OF EACH INSURANCE COMPANY'S GROUP), AND THEIR RESPECTIVE AUDITORS AND OTHER PROFESSIONAL ADVISORS, TRADE ORGANIZATIONS, AND/OR CLAIMS PROCESSES (THE "INSURANCE COMPANIES") ALL ASPECTS OF MY CLAIM FOR THE POLICY(IES) REFERENCED IN MY CLAIM FORM.

IN ADDITION, I, THE UNDERSIGNED, HEREBY AUTHORIZE THE DFS, HCPO AND THE INSURANCE COMPANIES TO INVESTIGATE THE CLAIM DESCRIBED IN MY CLAIM FORM AND FURTHER AUTHORIZE THEM TO MAKE AND USE COPIES OF DOCUMENTS CONTAINING PERSONAL DATA AND TO USE SUCH DATA TO INVESTIGATE THE CLAIM. THE UNDERSIGNED ACKNOWLEDGES THAT IN ORDER TO CARRY OUT THESE INVESTIGATIONS, IT MAY BE NECESSARY FOR THE DFS, HCPO AND THE INSURANCE COMPANIES TO PROCESS PERSONAL DATA INCLUDING SENSITIVE PERSONAL DATA AS DEFINED IN SECTION 119.07, FLORIDA STATUTES AND/OR ARTICLE 6-A (PERSONAL PRIVACY PROTECTION LAW] OF NEW YORK STATE'S PUBLIC OFFICERS LAW-WHICH IS SUBSTANTIALLY SIMILAR TO EUROPEAN DIRECTIVE NO 95/46 AND THE DATA PROTECTION ACT 1998 OF THE UNITED KINGDOM), AND TO DISCLOSE SUCH DATA TO THIRD PARTIES AND TO TRANSFER SUCH DATA, EVEN TO JURISDICTIONS THAT DO NOT PROVIDE THE SAME LEVEL OF PROTECTION FOR PERSONAL DATA AS EXISTS IN THE STATES OF FLORIDA AND NEW YORK; AND CONSENT TO PROCESSING, DISCLOSURE, AND TRANSFER OF SUCH DATA.

THE UNDERSIGNED ALSO AUTHORIZES INVESTIGATION IN ALL RELEVANT GOVERNMENT AUTHORITIES, NON-GOVERNMENTAL ORGANIZATIONS AND RELEVANT ARCHIVES AND FOR SUCH AUTHORITIES/BODIES/ORGANIZATIONS TO DISTRIBUTE ALL REQUESTED INFORMATION THE DFS, HCPO AND DESIGNATED INSURANCE COMPANIES.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____ PLACE: _____

