Exhibit C

EXHIBIT C

The DEADLINE to submit or mail this Claim Form is: <<CLAIM DEADLINE>>

Deborah Robin v. State Farm Mutual Automobile Insurance Company,
Case No. 24-391-SDD-RLB
United States District Court for the Middle District of Louisiana

Settlement Claim Form

If you are a Settlement Class Member and wish to receive a payment, your completed Claim Form must be postmarked on or before <<CLAIM DEADLINE>>, or submitted online on or before <<CLAIM DEADLINE>>.

Please read the full Notice of this settlement (available at **www.WEBSITE.com**) carefully before filling out this Claim Form.

To be considered, this Claim Form must be submitted online no later than ____ or mailed to the above address postmarked no later than _____.

To be eligible to receive any benefits from the settlement obtained in this class action lawsuit, you must submit this completed Claim Form online or by mail:

ONLINE: Submit a Claim Form at **www.WEBSITE.com**

MAIL: Robin v. State Farm
c/o Kroll Settlement Administration LLC
P.O. Box XXXXXX
New York, NY 10150-5391

Please read the full Notice of this settlement (available at **www.WEBSITE.com**) carefully before filling out this Claim Form.

Name & Address:
<<First Name>> <<Last Name>>
<<Address 1>>, <<Address 2>>
<<City>>, <<State>>, <<Zip>>

STATE FARM CLAIM ID: <<State Farm ID>>

Date of Loss: <<Date of Loss>>

PART ONE: CLAIMANT INFORMATION

Provide your name and address below if different than above. It is your responsibility to notify the Settlement Administrator of any changes to your contact information after the submission of your Claim Form. If you are submitting a Claim on behalf of a deceased or incapacitated Class Member, you must submit the supporting documentation necessary to demonstrate you are authorized to receive their benefit.

_____

FIRST NAME LAST NAME

_____

STREET ADDRESS

_____ ____ ____ ____ ____ ____

CITY STATE ZIP CODE

_____@_____

Email Address

PART TWO: ATTESTATION UNDER PENALTY OF PERJURY

AFFIRMATION (required): By signing below, I certify under oath that I am the person who made the insurance claim identified above or I am the legally authorized personal representative, guardian or trustee of the person who made the insurance claim identified above and that the information on this Claim Form is true and correct, that I am entitled to the relief requested in this Claim Form, and that I have not previously received a full and complete Purchasing Fees payment from State Farm on my underlying total loss claim. If this affirmation is not signed your claim will be denied.

_____ ____ ____ / ____ ____ / ____ ____ ____ ____

SIGNATURE **DATE**

_____

PRINT NAME