INSTRUCTIONS FOR COMPLETING PROOF OF CLAIM (POC) FORM

CLAIM NOTICE

As ordered by the Circuit Court of Cook County, Illinois, if you have a claim against the Company, you must present that claim to the Office of the Special Deputy Receiver (hereinafter referred to as "OSD") by the claim filing deadline. Please check your insurance company's page on our Web site **www.osdchi.com** for the claim filing deadline of the Company.

You must state the type of claim you have on the proof. If you have any documents to support your claim, for example, medical bills, payment receipts and/or cancelled checks, please submit copies with the POC form. If you do not have any such documents, attach a written statement indicating the amount the Company may owe you.

A claim shall be treated as filed as of the date it is received via facsimile by the OSD. It shall also be deemed to have been received as of the United States Postal Service's postmark date if it is mailed, or the date of delivery to a private mail courier for delivery to the OSD, as evidenced by a validly issued receipt from that courier.

PLEASE READ BEFORE COMPLETING PROOF OF CLAIM FORM

1. **Only one claim** may be filed per POC form. Please complete separate POC forms for each Contract, Treaty or Facultative Certificate.

2. If your claim is for unearned premiums, paid losses, allocated loss adjustment expenses (ALAE), outstanding loss reserves, and outstanding loss adjustment expenses or incurred but not reported losses (IBNR), write the amount.

3. If your claim is for commissions, specify type on POC form.

4. If your claim is for other account balances, provide description on POC form.

5. Once you have completed the form, please print two copies. One for your records and one for the OSD

6. **Please sign one of the printed forms, to subscribe and affirm that your claim and any accompanying documents are true to the best of your knowledge and belief, and return the signed form on or before the claim filing deadline**.

7. You may submit the form by mail or by facsimile to the following:

   - Address: Office of the Special Deputy Receiver
     222 Merchandise Mart Plaza, Suite 960
     Chicago, Illinois 60654-1309

   - Facsimile: (312) 836-1944

GENERAL INFORMATION

CHANGE OF ADDRESS - If you move after sending in your POC form, you must provide the OSD with your new address. Failure to do so could delay or hinder any distribution you may be entitled to receive.

NOTICE OF DETERMINATION (NOD) - When your claim is evaluated by the OSD, you will be notified as to the recommended allowance or disallowance of your claim, and if an allowance, the recommended amount. The law provides you with 60 days from the date of the notice in which to submit any inquiry or to lodge a written objection.

DISTRIBUTION OF ASSETS - After all timely-filed claims have been evaluated and adjudicated by the Supervising Court, claims that have been allowed will be paid ***pro rata***, by priority level, based upon available funds. The amount paid will depend upon the ratio of assets to total allowed claims. We will not know the final amount that can be paid on any individual claim until all claims are evaluated and all assets have been marshaled. We cannot project at this time the amount of assets that will be available for distribution on allowed claims.

Please call our office at (312) 836-9500 or check our Web site www.osdchi.com for posting of our Good Faith Estimates on the timing and amount of potential distributions.

IMPORTANT NOTICE: The OSD's acceptance of this POC form is not intended to constitute a waiver or relinquishment by the receiver of any defense, setoff or counterclaim that he/she may have against any person, entity or governmental agency.

REINSURANCE
CLAIM FORM

OSD **OFFICE OF THE SPECIAL DEPUTY RECEIVER**
Representing the Director of Insurance, State of Illinois

PROOF OF CLAIM IN THE MATTER OF Select Estate IN LIQUIDATION

REINSURANCE REFERENCE:

CEDENT OR CLAIMANT NAME:*	**CONTRACT/TREATY REF. NUMBER:***
DBA, LEGAL REPRESENTATIVE:	**FAC. CERT. REF. NUMBER:***
ADDRESS 1:*	**CONTRACT TYPE:**
ADDRESS 2:	**CONTRACT PERIOD:*** to
CITY/STATE/ZIP CODE/COUNTRY:*	**TAX I.D. NUMBER:***

IMPORTANT NOTICE: To participate in any distribution of assets of the Company made on allowed timely-filed claims, POCs must be received by the Office of the Special Deputy Receiver (hereinafter referred to as "OSD") on or before the **Claim Filing Deadline** **Select Estate**

No person having a contingent claim against the Company or an insured of the Company shall participate in any distribution of assets unless such claims are received by the OSD on or before the Claim Filing Deadline and are liquidated on or before the **Contingent Claim Deadline** **Select Estate**

PLEASE FILE A SEPARATE POC FOR EACH TREATY OR CONTRACT.

TYPE OF CLAIM

CLAIM IS FOR (Check appropriate boxes).

- ☐ Claim is made for Premium.
- ☐ Claim is made for Paid Losses.
- ☐ Claim is made for Paid Allocated Loss Adjustment Expenses (ALAE).
- ☐ Claim is made for Outstanding Loss Reserves.
- ☐ Claim is made for Outstanding Allocated Loss Adjustment Expenses.
- ☐ Claim is made for Incurred But Not Reported Losses (IBNR).
- ☐ Claim is made for Commissions. (Specify Type) _____
- ☐ Claim is made for Other Account Balances. (Provide a Description) _____

_____

STATUS OF CLAIM

CHECK APPROPRIATE BOXES.

- ☐ No part of the debt has been paid, except for _____
- ☐ There are no setoffs or counterclaims to the debt, except for _____
- ☐ There is no security for the debt, except for _____

AMOUNT OF CLAIM

- **PLEASE SUBMIT COPIES OF ALL SUPPORTING DOCUMENTATION IN ORDER FOR YOUR CLAIM TO BE CONSIDERED. IF YOUR CLAIM INCLUDES IBNR, YOU MUST PROVIDE REASONABLE SUPPORT, INCLUDING AN EXPLANATION OF HOW IT WAS CALCULATED BASED ON REASONABLE ACTUARIAL CERTAINTY.**
- **IF AMOUNT OF CLAIM IS UNKNOWN, ENTER THE WORDS "UNKNOWN AMOUNT." YOU MAY UPDATE THE AMOUNT OF YOUR CLAIM UNTIL A PREDETERMINED CUTOFF DATE IS SET BY THE SUPERVISING COURT.**

TOTAL AMOUNT OF CLAIM: $_____

THIS SECTION MUST BE COMPLETED

By completing this section, the undersigned subscribes and affirms that he/she has read the foregoing Proof of Claim and knows the contents thereof; that this claim is justly owing to claimant, and that the matters set forth above and in any accompanying documents are true to the best of his/her knowledge and belief.

_____ **Name of Claimant, Partner/Officer, or Legal Representative**

_____ **Signature***

_____ **Date***

_____ **Daytime Phone**

_____ **Mobile Phone**

_____ **E-mail Address***

***REQUIRED FIELDS**