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

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.
2. If your claim is for return of premiums, you do not have to state the amount. The amount will be determined from the Company records.
3. If the amount of claim is unknown, enter the words **"Unknown Amount".** You may amend the amount of your claim until it is adjudicated by the Supervising Court.
4. If you have a different type of claim against the Company, please provide a brief explanation of the claim on the POC form, including the amount claimed.
5. Once you have completed the form, please make two copies. One copy for your records and one copy for 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:
   - Mailing 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.

GUARANTY FUND COVERAGE - Claimants against the Company may be entitled to the protection of their state insurance Guaranty Association. A copy of any POCs filed with the OSD will be provided to the appropriate Guaranty Association. Amounts not covered by your Guaranty Association may become a claim against the remaining assets of the Company. Such amounts will be independently evaluated by the OSD.

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 any 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 the receiver may have against any person, entity or governmental agency.

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

PROOF OF CLAIM IN THE MATTER OF ________________________________

CLAIM CAPTION:

CLAIMANT NAME:*	**CLAIM NUMBER:**
DBA, LEGAL REPRESENTATIVE:	**LIQUIDATOR I.D. NUMBER:***
ADDRESS 1:*	**DATE OF LOSS:***
ADDRESS 2:	**POLICY NUMBER:***
CITY/STATE/ZIP CODE:*	**POLICY PERIOD***

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

PLEASE FILE A SEPARATE POC FOR EACH CLAIM.

MEDICAL CLAIMS

Complete this section if you have any bills that covered eligible services rendered, and or equipment supplied.

Insured Name________________________________ Certificate or Group No.________________________

Patient Name________________________________ Date of Birth________________________

Date(s) of Service________________________________ Have you paid for these expenses? ☐____ YES ☐____NO

PROVIDER OR MEDICAL SERVICES OR EQUIPMENT

Provider Name____

Address____

Contracted Provider? ☐____YES ☐_____NO Provider No.________________________

AMOUNT OF CLAIM

- **YOU MUST PROVIDE INDIVIDUAL ITEMIZED BILLS FOR EACH AND EVERY PATIENT TO WHOM YOU PROVIDED SERVICE(s) AND/OR EQUIPMENT.**
- **PLEASE SUBMIT COPIES OF ALL SUPPORTING DOCUMENTATION IN ORDER FOR YOUR CLAIM TO BE CONSIDERED.**
- **IF AMOUNT OF CLAIM IS UNKNOWN, ENTER THE WORDS "UNKNOWN AMOUNT". YOU MAY AMEND THE AMOUNT OF YOUR CLAIM UNTIL IT IS ADJUDICATED 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; 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**