



FOR OFFICE USE ONLY

PROOF OF CLAIM
IN THE MATTER OF

PROOF OF CLAIM NO. _____
DATE RECEIVED: _____

**LEGION INSURANCE COMPANY (IN LIQUIDATION) (LEGION) AND
VILLANOVA INSURANCE COMPANY (IN LIQUIDATION) (VILLANOVA)**

Deadline for filing: July 28, 2015 at 5:00 p.m. EST

READ ALL MATERIALS CAREFULLY BEFORE COMPLETING THIS FORM – COMPLETE ALL SECTIONS
FILL IN ALL BLANKS – PLEASE PRINT CLEARLY OR TYPE

DO NOT FILE A PROOF OF CLAIM IF:

- You have already filed a Proof of Claim for your claim;
- OR**
- Your claim has not ripened into a legal cause of action prior to **July 28, 2015**.

Claimant Name: _____
Address 1: _____
Address 2: _____
City: _____ State: _____ Zip Code: _____
Country: _____
S. S. /E.I.N. #: _____ e-mail: _____
Daytime Phone #: (include area code) _____

Name of Insured: _____
Policy Number: _____ Claim Number: (if previously filed) _____
Date of Loss: _____ Agent Number: _____

To Legion Indemnity Company policyholders: All information enclosed is directed to claimants against the estates of Legion Insurance Company (In Liquidation) or Villanova Insurance Company (In Liquidation). Legion Indemnity Company is a separate entity in liquidation by the Illinois Director of Insurance. Claims against Legion Indemnity Company may not be filed using the enclosed Proof of Claim form.

Claim is for (check X or specify below)

1	POLICYHOLDER or THIRD PARTY CLAIM	Claim by insured of Legion or Villanova under a Legion or Villanova policy for POLICY BENEFITS or Liability claim against an insured of Legion or Villanova for POLICY BENEFITS.
2	RETURN of UNEARNED PREMIUM or OTHER PREMIUM REFUNDS	Portion of paid premium not earned due to early cancellation of policy or retro or audit adjustment.
3	GENERAL CREDITOR	Such as Attorney fees, Adjuster fees, Vendors, Lessors, Consultants, Cedants and Reinsurers.
4	AGENTS' BALANCES	Agents' Earned Commissions.
5	ALL OTHER	Describe _____.

In the space below give a Concise Statement of the Facts giving rise to your claim. Attach additional sheets if required. _____

AMOUNT OF CLAIM: \$ _____

Is there OTHER INSURANCE that may cover this claim? Yes () No ()

If YES provide name of insurer(s) and policy number(s): _____

Does an ATTORNEY REPRESENT you? Yes () No () If YES provide attorney's name, address & telephone number: _____

Has a Lawsuit or other LEGAL ACTION been instituted by anyone regarding this claim? Yes () No () If YES provide the following:

Court Where Filed: _____

DATE FILED & DOCKET NUMBER: _____

PLAINTIFF (S): _____

DEFENDANT (S): _____

I verify that the statements made in this proof of claim are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 19 Pa. C.S. §4904 (relating to unsworn falsification to authorities).

If the foregoing Proof of Claim alleges a claim against a Legion or Villanova insured (third party claim), the undersigned hereby releases any and all claims which have been or could be made against such Legion or Villanova insured based on or arising out of the facts supporting the above Proof of Claim up to the amount of the applicable policy limits and subject to coverage being accepted by the Liquidator, regardless of whether any compensation is actually paid to the undersigned.

Claimant Signature

Date