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1 HPI 2017

IN THE COMMONWEALTH COURT OF PENNSYLVANIA

In Re: Healthcare Providers Insurance Exchange, In Liquidation	:	No. 1 HPI 2017

PRAECIPE TO SUBSTITUTE EXHIBITS TO LIQUIDATOR'S APPLICATION TO ESTABLISH A CLAIMS BAR DATE

1. On May 14, 2021, Insurance Commissioner Jessica K. Altman, in her capacity as Statutory Liquidator ("Liquidator") of Healthcare Providers Insurance Exchange ("HPIX"), filed her Application to Establish a Claims Bar Date ("Application") in the above-captioned matter.

2. The Application included a proposed Publication Notice as Exhibit B and a proposed Proof of Claim form as Exhibit C.

3. After the filing of the Application, it was determined that a word is misspelled in Exhibit B and that Exhibit C is not labeled as such at the top of its first page.

4. Accordingly, kindly substitute Exhibits B and C that were filed with the Application on May 14, 2021, with the attached Exhibits B and C, which correct the misspelling in Exhibit B and label Exhibit C as such, as mentioned in paragraph three above.

Respectfully submitted,

_____/s/ *Preston M. Buckman*__________________

PRESTON M. BUCKMAN (I.D. #57570)
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Attorney for Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Liquidator of Healthcare Providers Insurance Exchange, In Liquidation

Dated: June 22, 2021

<u>EXHIBIT B</u>

PUBLICATION NOTICE OF THE CLAIMS BAR DATE
<u>FOR HEALTHCARE PROVIDERS INSURANCE EXCHANGE (IN LIQUIDATION)</u>

NOTICE
TO THE POLICYHOLDERS, CLAIMANTS, CREDITORS AND
ALL OTHER PERSONS INTERESTED IN THE
AFFAIRS OF
HEALTHCARE PROVIDERS INSURANCE EXCHANGE (IN LIQUIDATION)

NOTICE IS HEREBY GIVEN THAT:

Healthcare Providers Insurance Exchange (In Liquidation) ("HPIX") was placed into Liquidation by Order of the Commonwealth Court of Pennsylvania, effective January 12, 2018, (the "Liquidation Order"). The Liquidation Order appointed the Insurance Commissioner of the Commonwealth of Pennsylvania as Statutory Liquidator of HPIX and vested her with title to all the property, assets, contracts and rights of action of HPIX.

On May 14, 2021, the Liquidator filed in the Commonwealth Court of Pennsylvania an Application to Establish a Claims Bar Date for HPIX. On ___________________, 202___, the Commonwealth Court entered an Order granting the Application and setting a Claims Bar Date of ___________________, 202__.

Therefore, all persons who may have a claim against HPIX, against the Liquidator, her agents or representatives, or in any way affecting or seeking to affect any of the assets of HPIX, wherever or however such assets may be owned or held, directly or indirectly, must file a Proof of Claim by the Claims Bar Date of _____________________, 202___, or the claim will be forever barred.

You may obtain a free copy of the Proof of Claim form by writing to Proof of Claim Department, Statutory Liquidator of Healthcare Providers Insurance Exchange, Pennsylvania Insurance Department, 901 North 7th Street, Harrisburg, PA 17102, or calling the Liquidator at 717-787-7823 or send an email to: ra-in-claims@pa.gov

EXHIBIT C

PROOF OF CLAIM
IN THE MATTER OF
HEALTHCARE PROVIDERS INSURANCE EXCHANGE (HPIX) (IN LIQUIDATION)

DO NOT FILE A PROOF OF CLAIM IF YOU HAVE ALREADY FILED A PROOF OF CLAIM OR YOUR CLAIM HAS NOT RIPENED INTO A LEGAL CAUSE OF ACTION PRIOR TO [fill in bar date]

Claimant Name: ____________________
Address 1: ____________________
Address 2: ____________________
City: ____________ **State:** ______ **Zip Code:** ________
Country: ____________
Social Security /E.I.N. #: ____________ **e-mail:** ____________
Daytime Phone #: (include area code)____________________

FOR OFFICIAL USE ONLY

PROOF OF CLAIM NO. ____________

DATE RECEIVED: ____________

Name of Insured/Bonded Principal ____________________
Policy Number/Bond Number: ____________ Claim Number: ____________
Date of Loss: ____________ Agent Number: ____________

Claim is for (check X or specify below)

1		POLICYHOLDER or THIRD PARTY CLAIM	Claim by insured of HPIX under a HPIX policy for POLICY BENEFITS or liability claim against an insured of HPIX 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, Cedents 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).

FOR ALL CLAIMS: In accordance with 40 P.S. §221.40(a), if the foregoing Proof of Claim alleges a claim against a HPIX insured (third party claim), the undersigned hereby releases any and all claims which have been or could be made against such HEALTHCARE PROVIDERS INSURANCE EXCHANGE 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

DO NOT FILE A PROOF OF CLAIM IF YOU HAVE ALREADY FILED A PROOF OF CLAIM OR YOUR CLAIM HAS NOT RIPENED INTO A LEGAL CAUSE OF ACTION PRIOR TO [fill in bar date]

INSTRUCTIONS FOR COMPLETING PROOF OF CLAIM FORM

This proof of claim form must be completed and returned. **Failure to return the completed form will result in the denial of your claim.** Please fill in all of the applicable blanks. Attach additional sheets as required. In the event you do not know certain information, please write "unknown". You may supplement your claim later when you have more information, provided you do so promptly after you obtain the information. Please print legibly in ink or type. The form may be duplicated. You are advised to keep a completed copy for your records. The following is some specific additional instruction for certain types of claims.

1. If your claim is regarding a **HPIX** policy, please complete as much of this form as possible and submit along with any supporting documentation. If additional documentation is required, you will be contacted.
2. If your claim is that of a **GENERAL CREDITOR**, please complete Section II, sign where indicated and attach supporting documentation such as all outstanding invoices.
3. If your claim is for the **AGENT BALANCES**, please complete Section II, sign where indicated and attach a complete accounting by policy/contract supporting your claim.
4. If you have **ANY OTHER** type of claim, describe your claim, i.e. stockholder, employee, taxes, license fees, assessments, etc. Please attach documentation supporting your claim.

The right (but not the obligation) to request additional supporting information is retained by the Liquidator. The failure to promptly provide such additional information may result in the denial of your claim.

The proof of claim form must be signed by the claimant, and must contain the claimant's current address and zip code. No claim can be considered for payment without a social security number or tax identification number. Where applicable, the name and address as well as the telephone number of the claimant's attorney, if any, must be shown. **YOU MUST FILE A SEPARATE PROOF OF CLAIM FORM FOR EACH CLAIM YOU MAKE.** IF YOU HAVE MORE THAN ONE CLAIM, YOU MAY MAKE COPIES OF THE ENCLOSED FORM, or go to Insurance Department's website, https://www.insurance.pa.gov/Regulations/LiquidationRehab/Pages/Healthcare-Providers-Insurance-Exchange.aspx, or call (717) 787-7823 for additional proof of claim forms. The following address should be used only to submit proof of claim forms and supporting documentation: Statutory Liquidator for **HPIX**, Capitol Associates Building, 901 N. 7th Street, Harrisburg, PA 17102 Phone: (717) 787-7823 You may also submit the Proof of Claim and supporting documents via email at ra-in-claims@pa.gov

NOTE: This form must be received no later than [fill in bar date] at 5:00 p.m. EST.

CHANGE OF ADDRESS
You are required by Article V of the Insurance Department Act to notify the Statutory Liquidator of your change of address. If you fail to do so you may jeopardize your chance of recovery from this estate.

INFORMATION REGARDING CLAIMS AGAINST THE ESTATE OF HEALTHCARE PROVIDERS INSURANCE EXCHANGE (HPIX)
After all claims against this company are evaluated by the Statutory Liquidator and approved by the Court, approved claims will be paid by priority level based on available funds in accordance with 40 P.S. § 221.1 et seq. The amount of the payment will depend on the assets available. The amount to be paid on an individual claim, if any, will not be known until all claims are evaluated. In any event, payment will not be made for several years. The Statutory Liquidator's receipt of this proof of claim form does not constitute any waiver or relinquishment by the Statutory Liquidator of any defense, setoff, or counterclaim that may exist against any person, entity or governmental agency, regarding any action pursued by the Statutory Liquidator of HPIX on behalf of HPIX claimants, and creditors.

CERTIFICATION OF COMPLIANCE
<u>WITH PUBLIC ACCESS POLICY</u>

I certify that this filing complies with the provisions of the Public Access Policy of the Unified Judicial System of Pennsylvania: Case Records of the Appellate and Trial Courts that require filing confidential information and documents differently than non-confidential information and documents.

____/s/ *Preston M. Buckman*____________

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PA Office of General Counsel
Pennsylvania Insurance Department
Capital Associates Building
901 North 7th Street
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(717) 886-2080

Attorney for Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Liquidator of Healthcare Providers Insurance Exchange, In Liquidation

Dated: June 22, 2021

CERTIFICATE OF SERVICE

I hereby certify that I am this day serving the foregoing document upon all parties of record in this proceeding, in accordance with the requirements of Pa. R.A.P. 3780, in the following manner:

Service via email and/or regular U.S. Mail addressed as follows:

Carl Maio, Esquire
CAMaio@foxrothschild.com
Healthcare Providers Insurance Exchange
1250 Camp Hill Bypass, Suite 108
Camp Hill, PA 17011

Steven Sawyer, Senior Vice President
Steven.Sawyer@MMICNC.com
Corporate Administration
700 Spring Forest Road, Suite 400
Raleigh, NC 27609

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1650 Market Street
Philadelphia, PA 19103
(215) 568-2000
(215) 568-0140 (Fax)

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/s/ *Preston M. Buckman*
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Attorney for Jessica K. Altman, Insurance Commissioner of the Commonwealth of Pennsylvania, in her capacity as Statutory Liquidator of Healthcare Providers Insurance Exchange, In Liquidation

Dated: June 22, 2021

COMMONWEALTH OF PENNSYLVANIA
GOVERNOR'S OFFICE OF GENERAL COUNSEL

June 22, 2021

Michael F. Krimmel, Chief Clerk
Commonwealth Court of Pennsylvania
601 Commonwealth Avenue, Suite 2100
P.O. Box 69185
Harrisburg, PA 17120-9185

Re: ***In Re: Healthcare Providers Insurance Exchange ("HPIX") (In Liquidation)***
No. 1 HPI 2017

Dear Mr. Krimmel:

Attached for filing please find a Praecipe to Substitute Exhibits to Liquidator's Application to Establish a Claims Bar Date with regard to the above-referenced matter.

Thank you for your assistance in this matter.

Very truly yours,

/s/ *Preston M. Buckman*

Preston M. Buckman
Insurance Department Counsel

PMB:drh

Enclosure

CAPITOL ASSOCIATES BUILDING | 901 NORTH 7TH STREET | HARRISBURG, PA 17102
Ph: 717-787-6009 | Fx: 717-772-4543 | www.insurance.pa.gov