PROOF OF CLAIM

IN THE MATTER OF

HEALTHCARE PROVIDERS INSURANCE EXCHANGE ("HPIX") (IN LIQUIDATION)

Claims Filing Deadline TBD

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

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, SUBSCRIBER or THIRD PARTY CLAIM	Claim by insured of HPIX under a HPIX policy for POLICY BENEFITS or liability claim against an insure 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: 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

INSTRUCTIONS FOR COMPLETING PROOF OF CLAIM FORM

This proof of claim form must be fully completed and returned. **Failure to return the fully completed form will result in the denial of your claim.** Please fill in all of the applicable blanks. **Failure to fully complete the form may result in your claim not being considered by the Liquidator**. Attach additional sheets as required. 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. For more information on these types of claims, please refer to the enclosed booklet.

1. If your claim is regarding a **HPIX** policy, please fully complete this form 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 your claim not being considered by the Liquidator.

The fully completed 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, www.insurance.pa.gov , 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

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. Section 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.