



**PROOF OF CLAIM**  
**IN THE MATTER OF**  
**SENIOR AMERICAN INSURANCE COMPANY ("SAIC") (IN LIQUIDATION)**

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

<b>Claimant Name:</b> _____ <b>Address 1:</b> _____ <b>Address 2:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Zip Code:</b> _____ <b>Country:</b> _____ <b>Social Security /E.I.N. #:</b> _____ <b>e-mail:</b> _____ <b>Daytime Phone #: (include area code)</b> _____	<b>FOR OFFICIAL USE ONLY</b>  <b>PROOF OF CLAIM NO.</b> _____  <b>DATE RECEIVED:</b> _____
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Claim is for (check X or specify below)

1	GENERAL CREDITOR	Such as Attorney fees, Adjuster fees, Vendors, Lessors, Consultants, Cedents and Reinsurers.
2	AGENTS' BALANCES	Agents' Earned Commissions.
3	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).

\_\_\_\_\_

Claimant Signature

\_\_\_\_\_

Date