FOR OFFICE USE ONLY

PROOF OF CLAIM NO. _____
DATE RECEIVED: _____

PROOF OF CLAIM

IN THE MATTER OF

PENNSYLVANIA CASUALTY COMPANY (IN REHABILITATION)

Deadline for filing November 4, 2009

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

Make corrections to Name & Address below

Claimant Name: _____
Address 1: _____
Address 2: _____
City: _____ State: _____ Zip Code: _____
Country: _____

Social Security /E.I.N. #: _____

Daytime Phone #: (include area code) _____

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

Claim is for (check X or specify below)

1		POLICYHOLDER or THIRD PARTY CLAIM	Claim by insured of Pennsylvania Casualty Company (PCC) under a PCC insurance policy for POLICY BENEFITS or Liability claim against an insured of PCC insurance 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).

If the foregoing Proof of Claim alleges a claim against a PCC insured (third party claim), the undersigned hereby releases any and all claims which have been or could be made against such PCC 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 Rehabilitator, 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 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 for **POLICY BENEFITS** please complete the front of this form. **If your claim is already filed with PCC**, you do not need to complete the proof of claim form unless you want to revise or amend your original claim. If additional documentation is required, you will be contacted. **If this is a new claim**, please attach documentation to support the claim.
   If your claim is a contingent claim under an insurance policy, use the space provided for policy benefits and indicate that the claim is contingent. If a policy was renewed, a claim should be filed for each policy number for which you want to file.
2. If your claim is for the **RETURN OF UNEARNED PREMIUM or other premium refunds**, please complete the front of this form. Please attach the appropriate documentation to support your claim.
3. If your claim is that of a **GENERAL CREDITOR,** please attach copies of all outstanding invoices to this form.
4. If your claim is for **AGENT BALANCES,** please attach a complete accounting by policy/contract in support of your claim.
5. If you have **ANY OTHER** type of claim, describe your claim, i.e., stockholder, employee, taxes, license fees, assessments. Please attach copies of information to support your claim.

The right (but not the obligation) to request additional supporting information is retained by the Rehabilitator. The failure to promptly provide such additional information may result in denial of the 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 the Insurance Department's website, www.insurance.state.pa.us, OR CALL (800) 382-1378 or (717) 766-1122 FOR ADDITIONAL PROOF OF CLAIM FORMS.**

You must sign the proof of claim form and mail it to:

Statutory Rehabilitator of Pennsylvania Casualty Company
P. O. Box 2025
Mechanicsburg, PA 17055-0719

NOTE: This form must be received no later than 5:00 PM EST on November 4, 2009.

CHANGE OF ADDRESS

You are required by Article V of the Insurance Department Act to notify the Statutory Rehabilitator of your change of address. If you fail to do so you may jeopardize your chance of recovery.

INFORMATION REGARDING CLAIMS AGAINST PENNSYLVANIA CASUALTY COMPANY

After all claims against this company are evaluated by the Statutory Rehabilitator 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.

The Statutory Rehabilitator's receipt of this proof of claim form does not constitute any waiver or relinquishment by the Statutory Rehabilitator of any defense, setoff, or counterclaim that may exist against any person, entity or governmental agency, regarding any actions pursued by the Statutory Rehabilitator of Pennsylvania Casualty Company on behalf of Pennsylvania Casualty Company claimants, policyholders and creditors.