FRIDAY HEALTH PLANS OF NEVADA, INC.

PROOF OF CLAIM FORM

Proof of Claim Number:

RETURN THIS COMPLETED PROOF OF CLAIM FORM WITH NECESSARY SUPPORTING DOCUMENTATION TO:

Friday Health Plans of Nevada, Inc. in Receivership
ELLINGSON & ASSOCIATES, LLC
9348 E. Wood Drive
Scottsdale, Arizona 85260

Please carefully read the Receivership Claims and Appeal Procedure & Instructions PRIOR to completing this Proof of Claim Form. Please print or type.

NAME OF CLAIMANT	TOTAL AMOUNT OF CLAIM
STREET ADDRESS	SOC. SEC. OR TAX ID NUMBER
CITY STATE ZIP	TELEPHONE NO.
EMAIL ADDRESS	FACSIMILE NO.

If the Claimant is represented by an attorney, please complete the section below:

NAME OF CLAIMANT ATTORNEY	STATE BAR NO.
NAME OF LAW FIRM	TAX ID NUMBER
STREET ADDRESS	TELEPHONE NO.
CITY STATE ZIP	FACSIMILE NO.
EMAIL ADDRESS	

All claims submitted to the Special Deputy Receiver shall set forth in reasonable detail the amount of the claim, or the basis upon which that amount can be ascertained, the facts upon which the claim is based, and the priorities asserted, if any. Claims must be verified by the affidavit of the Claimant (or someone authorized to act on behalf of the Claimant and having knowledge of the facts) and be supported by the applicable written documentation or proof.

Explanation of Claim:

(Attach additional pages if necessary. If this is a policy claim, please include policy and claim number(s) and state whether or not the claim has previously been reported to Friday Health or Friday Health's claim administrator.)

Unless noted herein, I alone am entitled to file this claim, no others have an interest in this claim, no payments have been made on the claim, no third party is liable on this debt, the sum claimed is justly owing, and there is no set-off. The undersigned subscribes and affirms as true under the penalties of perjury under the laws of the State of Nevada as follows: that he or she has read the foregoing Proof of Claim Form and knows the contents thereof; that this claim against the Company is justly owing to the Claimant; that the matters set forth and in any accompanying statements and supporting documents are true and correct.

PRINT NAME OF CLAIMANT OR AUTHORIZED AGENT

SIGNATURE OF CLAIMANT OR AUTHORIZED AGENT

TITLE

NOTE: ATTACH DOCUMENTATION TO SUPPORT YOUR CLAIM.