To Be Completed by SDR
POC # _____
Claim # _____
Date Received _____

Filing Deadline:
September 5, 2024
11:59 p.m. Central Daylight Time

FRIDAY HEALTH INSURANCE COMPANY, INC.
PROOF OF CLAIM

Return this completed Proof of Claim form and any supporting documents. A Proof of Claim must be **postmarked or received** by the SDR no later than **11:59 p.m. Central Daylight Time on September 5, 2024,** at one of the addresses shown below.

BY MAIL:
CANTILO & BENNETT, L.L.P.
Special Deputy Receiver
Friday Health Insurance Company, Inc.
P.O. Box 184
Austin, Texas 78767
ATTENTION: CLAIMS

BY COURIER OR HAND DELIVERY:
CANTILO & BENNETT, L.L.P.
Special Deputy Receiver
Friday Health Insurance Company, Inc.
11401 Century Oaks Terrace, Suite 300
Austin, Texas 78758
ATTENTION: CLAIMS

Please read the Proof of Claim instructions carefully before completing this Proof of Claim. Please print or type.

_____ $_____
Name of Claimant — Total Amount of Claim

_____ _____
Street Address — Soc. Sec. or Tax ID Number

_____ _____
City State Zip — Telephone Number

_____ _____
E-mail Address — Facsimile Number

If the claimant is represented by an attorney, please complete the following section, and attach a copy of the Power of Attorney:

_____ _____
Name of Attorney — State Bar No.

_____ _____
Name of Law Firm — Tax ID Number

_____ _____
Street Address — Telephone Number

_____ _____
City State Zip — Facsimile Number

_____
E-mail Address

Provide an explanation of your claim below, and state if there is any security on the claim or any payments that have been made on the claim. Attach additional pages if necessary.

NOTE: ATTACH DOCUMENTATION TO SUPPORT YOUR CLAIM

AFFIRMATION OF CLAIMANT

Texas law requires the following statement in a Proof of Claim

Unless otherwise stated in this proof of claim:

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 counterclaim, or defense to the claim. I declare, under penalty of perjury, that all of the statements made in this Proof of Claim and all documents attached to this form are true, complete, and correct. If I am making a claim against a person insured by Friday Health Insurance Company, Inc., I understand that I am waiving any right to pursue the personal assets of that person, to the extent of the coverage and limits provided by the policy issued by Friday Health Insurance Company, Inc.

_____
Signature

_____
Print Name

State of _____

County of _____

The foregoing instrument was acknowledged before me this _____ day of _____ 20___, by _____, who has executed this instrument on such individual's own behalf, who is personally known to me or who has produced a Driver License or other information as identification.

_____
Notary Public

_____
Printed Name

My Commission Expires: _____

(NOTARY SEAL)