| **PROOF OF CLAIM**<br>**IN THE MATTER OF**<br>***FRIDAY HEALTH PLANS OF NORTH CAROLINA, INC. (FHPNC)***<br>**Deadline: 11:59 PM EDT, JULY 1, ,2024** | *FOR OFFICIAL USE ONLY*<br><br>PROOF OF CLAIM NO.: |
|---|---|

**Please Read Proof of Claims Instructions Carefully Before Completing All Sections Please Print or Type**
**Policyholders do NOT need to file a proof of claim at this time.**

**SECTION I**

Claimant Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone No. ( ) _____ FAX Number: ( ) _____

FEIN No: _____ E-Mail Address: _____

Social Security No: _____

**SECTION II** Claim is for (mark with an "X")

| | | | |
|---|---|---|---|
| 1 | | POLICYHOLDER CLAIM | Claim by Insured of FHPNC for policy benefits. |
| 2 | | GENERAL CREDITOR | Attorney fees, Vendors, Landlords, Lessors, Consultants, Cedants, and Reinsurers Describe in an attachment. - if secured debt please provide description of security. |
| 3 | | BROKER/AGENT | Agent earned commissions. |
| 4 | | ALL OTHER | Describe in an attachment. -if secured debt please provide description of security. |

**SECTION III**

1. **In an attachment** provide a concise statement of the facts giving rise to your claim, including but not limited to any consideration given for the claim, the identity and amount of any security on the claim, and any right of priority of payment asserted by the claimant or any other specific right asserted by the claimant.

2. Amount of Claim (or estimate) $ _____ If amount of claim is unknown, insert words "Unstated Amount."

3. Have any prior payments been made on this claim? YES ( ) NO( ) If yes, please describe in an attachment.

4. Is there OTHER INSURANCE that may cover this claim? YES ( ) NO ( _). If YES, provide name of insurer(s) and policy number(s): _____

5. You may amend your timely filed claim up until the final date that your claim is adjudicated. Please attach all documents, contracts, and invoices supporting your claim. If they are voluminous, please attach a summary. Please include any right of priority of payment or other specific right asserted by the party filing the proof of claim.

**SECTION IV**

1. Does an ATTORNEY REPRESENT you? YES ( ) NO ( ) If yes, provide attorney's name, address & telephone number:

_____

2. Has a Lawsuit or other LEGAL ACTION been instituted by anyone regarding this Claim? YES ( ) NO ( ) If YES, please provide the following:
   Court where Filed: _____ DATE FILED _____ DOCKET NUMBER: _____

   PLAINTIFF(S): _____

   DEFENDANT(S): _____

**SECTION V**

The undersigned affirms under the penalties of perjury that the following facts are true: that the undersigned has read the foregoing Proof of Claim and all attachments and knows the contents thereof; that the claim described above against Friday Health Plans of North Carolina, Inc. in Receivership is true to the best of the undersigned's knowledge; is justly owing, that no payment of the claim has been made except as stated above; and that there are no setoff, counterclaims, or defense thereto.

_____ _____ _____

**Claimant Signature** **Title or Official Capacity** **Date**

## INSTRUCTIONS FOR COMPLETING PROOF OF CLAIM FORM

This proof of claim form is used for filing a claim against Friday Health Plans of North Carolina, Inc. ("FHPNC"). If you have a claim against FHPNC, you must file a completed proof of claim form with the Receiver by the bar date. To file by the bar date the proof of claim form must be **received by Receiver no later than 11:59 PM EDT on July 1, 2024**. Failure to file a timely claim may result in denial of your claim or consideration of your claim. Policyholders do NOT need to file a proof of claim at this time.

Please print legibly in ink or type. Complete all of the applicable sections and blanks, read and sign. Attach additional sheets as necessary. In the event you do not know certain information, please write "unknown." You may supplement your proof of claim when you have more information, provided you do so promptly after you obtain the information. If you have more than one claim against FHPNC a separate proof of claim must be submitted for each claim. You may make copies of the proof of claim form, request additional copies from the Receiver using the address below or download the form from the Receiver website at: https://fridayhealthplansofnorthcarolina-inreceivership.com/ or the NCDI's website at: https://www.ncdoi.gov/insurance-industry/regulatory-actions-receiverships A proof of claim must be filed even if a claim was made against FHPNC prior to receivership. You are advised to keep a completed copy for your records.

Whenever a claim is based upon an instrument in writing, a copy of the document should be attached to the proof of claim. If the document has been destroyed, a statement of the facts and circumstances of the loss must be filed, under oath, with this claim. The right (but not the obligation) to request additional supporting information is retained by the Receiver. The failure to promptly provide such additional information may result in denial of the claim.

Early submission of your Proof of Claim form(s) will allow the Receiver to resolve any issues in a timely manner. The Court governs the timing and final payment of approved claims.

**Section I:**
Complete requested contact and policy information. Ensure claimant's address is current including a correct zip code. **You are required to notify the Receiver of your change of address.**

**Section II:**
Please denote the type of claim you are making against FHPNC:

**1.** A **policy benefit** claim represents unpaid claims arising under the policies issued by FHPNC. **Even if you have a claim already pending with FHPNC you must file a proof of claim,** but it is not necessary for you to attach additional documentation**. If this is a new claim,** complete the form and attach documentation to support the claim. *If your claim is a contingent claim under an insurance policy, please note as such.*

2. Claim of a **general creditor** includes claims falling under NCGS 58-30-220 (5). Attach copies of all outstanding invoices to this form.

3. Claims for **broker/agent** refers to outstanding broker/agent earned commissions. Attach a complete accounting by policy in support of your claim.

4. **Any other** type of claim includes outstanding claims not listed above, other than claims falling under NCGS 58-30-220 (1) and (2). Describe your claim and attach copies of supporting information.

5. **Designation of type of claim by the claimant does not determine the correct class or validity of any claim. The Receiver will determine the correct class and validity of each claim.**

**Section III:**
Complete requested claim information including a concise statement of the facts giving rise to your claim in a **separate attachment**.

**Section IV:**
Complete regarding legal representation and/or legal actions. The name, address, and telephone number of the claimant's attorney, if any, must be shown. Attach additional sheets as necessary.

**Section V:**
The claimant needs to sign and date the form affirming the accuracy of the information provided. ***Note: N.C. General Statute §58-2-161(b) provides in substance that any person who, with the intent to deceive, injure or defraud an insurer, presents or causes to be presented a written or oral statement in support of a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains false or misleading information material to the claim, is guilty of a Class H felony.***

**Filing:**
**A complete and signed proof of claim form must be postmarked or received by the Receiver no later than 11:59 PM EDT on JULY 1, 2024.** Please retain a copy for your records. Submit to the Receiver at the following address:

**Friday Health Plans of North Carolina In Receivership**
**145 N. Main St.**
**P.O. Box 519**
**Stuart, VA 24171**

**IMPORTANT MAILING INFORMATION: The Receiver is not responsible for undelivered mail. To protect your personal information, the Receiver recommends certified mail or some other service such as FedEx or UPS. Do not send the form by unsecured email.**

**Notes:**
**Claims will be adjudicated, as applicable, in accordance with the North Carolina Statute Chapter 58, Article 30, applicable policy and contract provisions, applicable guaranty fund statutes and/or the Receivership Order or subsequent orders issued by the Receivership Court. Appeal guidelines are found in North Carolina Statute 58-30-205.**

After all claims against this company are evaluated by the Receiver and allowed claims are approved by the Court, approved claims will be paid by priority level based on available funds in accordance with N.C. General Statute §58-30-220. The amount of the payment will depend on the assets recovered. The amount to be paid on an individual claim, if any, will not be known until all claims are evaluated and assets are recovered. In any event, payment, if any, will not be made for several years.

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