FRIDAY HEALTH PLAN OF GEORGIA, INC., IN LIQUIDATION - PROOF OF CLAIM

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

LIQUIDATOR USE ONLY

PROOF OF CLAIM NO.: _____
DATE RECEIVED: _____

Name of Claimant: _____ **E-Mail Address: _____**

Address of Claimant: _____ **Phone No.: _____**

If claimant is represented by an attorney, please complete the following box:

Name of Attorney: _____ **E-Mail Address: _____**

Address of Attorney: _____ **Phone No.: _____**

All Claimants must keep the Liquidator advised of any address changes subsequent to the filing of the Proof of Claim or receipt of this notice. All communications to the Liquidator should identify the Claim Number to the extent known.

Policyholder Name: _____
Policy Number: _____

This Claim is for:

- ❑ **Loss under Policy (Claim by Insured of FHPGA for policy benefits)**
- ❑ **Unearned premium refund (Portion of paid premium not earned due or retro or audit adjustment)**
- ❑ **General Creditor (Attorney fees, Adjuster fees, Vendors, Landlords, Lessors, Consultants, Cedants, & Reinsurers)**
- ❑ **All Other (Describe)**

In the space below, give a concise statement of facts giving rise to your Claim:

_____

_____

_____

_____

_____

_____

AMOUNT OF CLAIM: $ _____

ATTACH COPIES OF ANY SUPPORTING DOCUMENTS SUCH AS CORRESPONDENCE, LAWSUITS, JUDGEMENTS, PREMIUM RECEIPTS, CANCELED CHECKS, ETC.

State of_____ **County of**_____

I HEREBY SWEAR OR AFFIRM UNDER PENALTY OF PERJURY THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE STATEMENTS AND ATTACHED SUPPORTING DOCUMENTS IN THIS CLAIM ARE TRUE AND CORRECT.

X _____

Claimant's Signature Date

Sworn and subscribed
Before me this _____ day of _____, 202__

_____ [SEAL]

Notary Public, State of Georgia
My Commission Expires_____

NOTICE: ALL PROOFS OF CLAIMS MUST BE RECEIVED BY THE LIQUIDATOR AT THE FOLLOWING ADDRESS ON OR BEFORE JUNE 2, 2024, OR BE FOREVER BARRED.

FRIDAY HEALTH PLANS OF GEORGIA, INC., IN LIQUIDATION
P.O. Box 519
Stuart, VA 24171

RETURN OF UNEARNED PREMIUM OR OTHER PREMIUM REFUNDS:

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.

GENERAL CREDITOR CLAIM:

If your Claim is that of a **General Creditor**, please attach copies of all outstanding invoices to this form.

ALL OTHER:

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.

PROOF OF CLAIM FORM

The Proof of Claim must be completed in its entirety and all questions must be answered. Should there be questions that do not apply to your situation, simply complete each blank that does not require an answer with "N/A" or "not applicable." Make sure that your form is *signed under oath before a notary public*. Mail it together with all supporting documentation to the address shown below. Proof of Claim forms must be *received no later than June 2, 2024*. Mail Proof of Claim to*:

Friday Health Plans of Georgia, Inc. In Liquidation
P.O. Box 519
Stuart, VA 24171

All Claimants must keep the Liquidator advised of any address changes subsequent to the filing of the Proof of Claim or receipt of this notice. All communications to the Liquidator should identify the Claim Number to the extent known.

By Order of the Liquidation Court dated June 2, 2023, Friday Health Plans of Georgia, Inc. was placed into liquidation on August 1, 2023.