PROOF OF CLAIM

CONSUMERS' CHOICE HEALTH INSURANCE COMPANY (CONSUMERS' CHOICE) IN LIQUIDATION

ALL CLAIMS MUST BE POSTMARKED BEFORE THE CLAIM FILING DEADLINE OF 5:00 PM EASTERN TIME ON DECEMBER 31, 2016. READ CAREFULLY BEFORE COMPLETING. SEE INSTRUCTIONS ON BACK

FOR OFFICE USE ONLY:		
Date Postmarked:	Interested Party Name:	
Date Received:	Address:	
Proof of Claim No:	ID#:	Policy#:
Liquidator Allowed Amount:	Liquidator Denied Amount:	Court Allowed Amount:

CLAIMANT INFORMATION	**Claimant Please Complete – Print (black ink) or Type**
Name:	
Address: (Include City, State & Zip Code)	Policy Period, if applicable:
Home Phone:	Insured, if applicable:
Work Phone:	Existing Claim Number (if any):
SSN or TIN:	Claim Date(s) of Service:

CLAIM INFORMATION All supporting documentation must be attached to Proof of Claim in order to be considered.

Claim is for:

Policyholder/Insured

	Amount of Claim
☐ Claim is made for a specific loss or occurrence arising under coverage of the following type:	
☐ Unpaid benefits arising under the coverage of a Consumers' Choice policy or contract	
☐ Other – Specify Type: _____	
☐ Claim is made for the return of premium due to overpayment or early cancellation (If amount is unknown, Liquidator will calculate). Amount of premium/consideration paid to date _____. Attach copies of cancelled checks or other proof of payments.	_____

All Other Claimants:

☐ U.S. Government claim	_____
☐ Secured claim	_____
☐ Salary or wages for services performed	_____
☐ Governmental entity claim for fees, taxes, penalties or forfeitures	_____
☐ Unpaid legal or professional expenses	_____
☐ Unpaid commissions or general creditor invoices.	_____
☐ All others: state particulars of claim, including consideration given for this claim and attach supporting documentation, including a copy of written instrument which is the foundation of the claim.	_____

Please provide the exact amount of your claim and each component. Attach supplemental documentation, if available, to support your claim.

TOTAL AMOUNT OF CLAIM: **$_____**

For below, please provide an explanation. Use separate sheets if necessary.

What payments have you received for this claim, if any, from Consumers' Choice?

Is there security for this debt?

Do you assert any right of priority pursuant to S.C. Code Ann. § 38-27-610 or other specific right with respect to your claim? _____

Are there set-offs, counterclaims or defenses to this debt? ☐ Yes ☐ No If yes, please describe. _____

STATUS OF CLAIM

- ☐ Claim is based on a court judgment or settlement (attach judgment or agreement).
- ☐ Claim currently pending in court (provide details and documentation).
- ☐ Claim is not yet filed in court.
- ☐ New claim not previously reported to Consumers' Choice.
- ☐ Other insurance is available to cover this claim.

Name and address of your attorney if any:

Name: _____

Company: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Phone: _____

VERIFICATION

The undersigned subscribes and affirms as true under penalty of perjury as follows:

I have read the foregoing Proof of Claim and know the contents thereof: that this claim of $_____ against Consumers' Choice Health Insurance Company is justly owing to the claimant; that there is no set-off, counterclaim or defense to the claim thereto, except as above stated; that the matters set forth above and in any accompanying statements are true to my knowledge except as matters specifically stated to be alleged upon information and belief and that as to such matters, I believe them to be true; that no payment of or on account of the aforesaid claim has been made, except as stated above.

Date Signed: _____

Subscribed and sworn to me this _____ day of _____, 20____.

Signature of Notary Public/Commissioner of Oaths

State of _____ County of _____

My commission expires: _____

(Seal)

_____
Print or Type Name of Claimant, Partner, Officer or Legal Representative

_____
Signature of Individual, Partner, Officer, or Legal Representative

_____
Title or Official Capacity

Home Phone (_____)_____

Work Phone (_____)_____

_____
Social Security Number or FEIN of Claimant

See reverse side for mailing and other instructions

PROOF OF CLAIM INSTRUCTIONS
All Claims

This Proof of Claim ("POC") should be completed in its entirety and all questions answered.

Please note certain instructions and requirements are contained in the POC itself. A separate POC form should be completed for each claim asserted against Consumers' Choice Health Insurance Company (Consumers' Choice). Additional forms may be obtained from Claimant Services at the address set forth below or at our website (www.cchpsc.com). For questions that do not apply to your claim situation, your response should be indicated with an "NA" or "not applicable."

You must explain in detail the basis of your claim and provide as an attachment all supporting documentation. If needed supporting documentation is not available, you must attach an explanation of why the documentation is not available.

If your claim is for return of premiums, you do not have to calculate the amount. However, you may enter the amount, if known. You must include proof of payment of last premium(s).

If your claim is for health plan benefits, please provide the explanation of the benefits (EOB). For other types of claims against Consumers' Choice, provide a brief explanation of the claim, the amount claimed, and documentation supporting the claim. If you do not know the amount of the claim, write "unstated amount."

You must sign the POC form and have it notarized. Please refer to the instructions in the attached "Notice" as to who should sign the claim form.

Please retain a copy for your records and mail the original to:

Claimant Services
Consumers' Choice Health Insurance Company
9821 N. 95th St. Suite 105
Scottsdale, AZ 85258

THE LAST DAY FOR FILING TIMELY CLAIMS AGAINST CONSUMERS' CHOICE HEALTH INSURANCE COMPANY IN LIQUIDATION IS 5:00 PM Eastern Time on December 31, 2016. Claims must be postmarked (not postage meter stamped) no later than 5:00 PM Eastern Time on December 31, 2016.

You will be advised of receipt of your completed POC and your POC number. You will be notified some time thereafter of the Liquidator's decision regarding your claim. If your claim is denied in whole or in part by the Liquidator, and you dispute the Liquidator's findings, you will have the opportunity to present your dispute to the Liquidation Court in Richland County, or a forum designated by the Court.

The Liquidator's acceptance of the POC is not intended to, nor does it constitute, a waiver or relinquishment by the Liquidator of any defense, set-off or counterclaim which the Liquidator may have against any person, entity or governmental agency.

All claimants are requested to keep the Liquidator advised of address changes. Inquiries as to the status of your claim should be made in writing. Please identify your POC number in all correspondence to permit ease of identification and an expedited response.

Consumers' Choice's website (www.cchpsc.org) is a source for news and information regarding the ongoing liquidation.