PROOF OF CLAIM

CARECONCEPTS INSURANCE, INC., A RISK RETENTION GROUP (CARECONCEPTS) IN LIQUIDATION

ALL CLAIMS MUST BE POSTMARKED BEFORE THE CLAIM FILING DEADLINE OF 5:00 PM MOUNTAIN DAYLIGHT TIME ON MARCH 31, 2017. 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:	Date Claim Incurred:

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

Claim is for:

Policyholder/Insured

☐ Claim is made for a specific loss or occurrence arising under coverage of the following type: **Amount of Claim**

☐ Long Term Care Facilities Liability Policy
☐ Other – Specify Type: _____ _____

☐ Claim is made for the return of premium due to overpayment or unearned premium due to 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. Was Premium financed? ☐Y or ☐N If yes, provide premium finance company and details of premium financing: _____ _____

All Other Claimants:

☐ Claim is made against policyholder/insured for a specific loss or occurrence arising under coverage of the following type: _____

☐ Long Term Care Facilities Liability Policy
☐ Other – Specify Type: _____ _____

☐ 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 CareConcepts? _____

Is there security for this debt? _____

Do you assert any right of priority pursuant to MT Code Ann. § 33-2-1371 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 CareConcepts. Date Reported: _____
☐ 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 CareConcepts Insurance, Inc., a Risk Retention Group 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: _____

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

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

Signature of Notary Public/Commissioner of Oaths

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

State of _____ County of _____

_____
Title or Official Capacity

My commission expires: _____

Home Phone (_____)_____

Work Phone (_____)_____

_____
Social Security Number or FEIN of Claimant

(Seal)

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 CareConcepts Insurance, Inc., a Risk Retention Group (CareConcepts). Additional forms may be obtained from Claimant Services at the address set forth below or at our website (www.careconceptsinliquidation.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 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 a loss or other policy benefits, please provide a clear explanation of the loss or accident. For other types of claims against CareConcepts, provide a brief explanation of the claim, the amount claimed, and any documentation that supports the claim. If you do not know the amount of the claim, write "unstated amount."

You must sign this 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 of your completed POC form and mail the original to:

Claimant Services
CareConcepts Insurance, Inc., a RRG in Liquidation
8701 E. Vista Bonita Dr., Ste. 200
Scottsdale, AZ 85255

THE LAST DAY FOR FILING TIMELY CLAIMS AGAINST CARECONCEPTS INSURANCE, INC., a RISK RETENTION GROUP IN LIQUIDATION IS 5:00 pm Mountain Daylight Time on March 31, 2017. Claims must be postmarked (not postage meter stamped) no later than 5:00 PM Mountain Daylight Time on March 31, 2017.

You will receive written advice of our 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 Lewis & Clark 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 specifically identify your POC number in all correspondence to permit ease of identification and an expedited response.

CareConcepts' website (www.careconceptsinliquidation.com) is a source for news and information regarding the ongoing liquidation.