PROOF OF CLAIM

AGAINST FAIRWAY PHYSICIANS INSURANCE COMPANY, A RISK RETENTION GROUP IN LIQUIDATION

Payment, if any, will be made and sent to the name and address in Items 1-2.

1. **CLAIMANT NAME** _____
2. **CLAIMANT ADDRESS**_____

   _____

   _____

For Items 3-6, if represented by counsel, please provide the attorney's information.

3. **CLAIMANT FEDERAL TAX ID#** _____
4. **CONTACT NAME** _____
5. **CONTACT PHONE NUMBER** _____
6. **CONTACT EMAIL ADDRESS** _____

CLAIM INFORMATION

7. **TYPE OF CLAIM** ☐ **INSURED (loss/claims)** ☐ **GENERAL CREDITOR (and claims for premium refunds)** ☐ **OTHER (EXPLAIN)**_____
8. **If insured, POLICY NUMBER**_____
9. **AMOUNT OF CLAIM $**_____
10. **DESCRIPTION OF CLAIM -** Attach a description of the following: (1) the details of the claim and why a Proof of Claim is being submitted; (2) if general creditor, the identity and amount of the security on the claim (if applicable); (3) any payments already received for the claim; and (4) if general creditor, any right of priority of payment or other specific rights asserted.
11. **SUPPORTING DOCUMENTS –** Attach copies of any written instruments or documents supporting the information provided for item 10.

PROOF OF CLAIM MUST BE RECEIVED BY U.S. POSTAL SERVICE OR OTHER COMMERCIAL CARRIER <u>NO LATER THAN 5:00 P.M. APRIL 25, 2018</u> AT:

PROOF OF CLAIM DEPARTMENT
9543 FENWAY AVENUE
BATON ROUGE, LOUISIANA 70809

FACSIMILE AND EMAIL OF THIS FORM WILL NOT BE ACCEPTED.

I attest that Fairway Physicians Insurance Company, A Risk Retention Group is indebted to the claimant listed herein, and this Proof of Claim, including all documents attached, are true and correct. I assert that the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim. Should any of the information provided change, including the receipt of monies from other sources for the claim contained herein, I will immediately contact the Special Deputy Liquidator at (225) 201-0107 or by email to billy.bostick@fairwayphysicians.com and report the change(s). I understand that if my contact information provided herein changes it is my obligation to provide updated information to the Special Deputy Liquidator. I acknowledge that if I fail to provide such updated information, the Special Deputy Liquidator will have no obligation to seek this updated information from any source.

AUTHORIZED SIGNATURE_____ **DATE**_____

AUTHORIZED SIGNER NAME (PLEASE PRINT) _____

AUTHORIZED SIGNER TITLE (IF APPLICABLE) _____

NOTARY
(Form must be stamped or contain raised seal)

STATE OF _____
COUNTY OF _____

On this, the _____ day of _____, 20___, before me a notary public, the undersigned _____ personally appeared, known to me to be the person whose name is subscribed to the within instrument, and acknowledged that he/she executed the same for the purposes therein contained.

In witness hereof, I hereunto set my hand and official seal.

_____
Notary Public

My commission expires at _____