# PROOF OF CLAIM

Family Health Hawaii, MBS
In Liquidation ("Family Health" or the"Company")
PO Box 1350
Honolulu, HI 96807-1350

In the Circuit Court of the First Circuit
State of Hawaii
S.P. No. 16-1-0086 KTN

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING FORM

**DEADLINE FOR FILING PROOF OF CLAIM IS: DECEMBER 15, 2016**

**Proof of Claim Number:**

***Part 1** Person or Entity Making Claim (Claimant)*

| | |
|---|---|
| **Claimant Name:** | |
| **Address 1:** | **Claimant Telephone:** |
| **Address 2:** | **Claimant E-Mail:** |
| **City:** **State:** **ZIP Code:** | **Social Security or Federal Tax ID No.:** |

Are you represented by an attorney? Yes or No , circle one
If yes, state your attorney's name, address and telephone number _____
_____

***Part 2** Claim Information*

Family Health Liabilities fixed as of April 7, 2016

| Type of Claim | Amount of Claim |
|---|---|
| ☐ Policyholder | $ _____ |
| ☐ General Creditor | $ _____ |
| ☐ Medical Provider | $ _____ |
| ☐ Insurance Producer | $ _____ |
| ☐ Other | $ _____ |

Describe your claim: _____
_____

Attach all supporting documentation to this form.

a. Have you received any payments on the claim for which you are filing this Proof of Claim from any source? ____If yes, specify the total amount received $ _____ and identify all sources:_____
_____

b. Is this a secured claim? If yes, identify all security for this claim: _____
_____

c. Is this claim the subject of legal action? If yes, list court and case number: _____
List all parties and their attorneys:_____

d. Is this claim contingent or unliquidated? If yes, explain: _____

e. Do you claim any right of priority of payment? If yes, please explain: _____
_____

The undersigned subscribes and affirms as true under the penalties of perjury as follows: that he or she has read the foregoing Proof of Claim and knows the contents thereof; that this claim against the Company is justly owing to the Claimant; that the matters set forth and in any accompanying statements and supporting documents are true and correct; that no payment of or on account of the aforesaid claim has been received except as above stated; and that there are no setoffs, counterclaims, or defenses thereto except as above stated.

**Claimant Signature**_____ **Date Signed** _____

**Print Name**_____

**Title or Official Capacity (if any)** _____

**Return your completed form to:**

Family Health Hawaii, MBS (In Liquidation)
ATTN: Proof of Claim
P.O. Box 1350
Honolulu, HI 96807-1350

## IMPORTANT NOTICE

If you change your address after filing your Proof of Claim you must provide us with your new address in order to receive any notification or payment that might be due.

## PROOF OF CLAIM INSTRUCTIONS

1. The Proof of Claim must be typed or legibly printed in ink.

2. The Proof of Claim must have all items completed and questions answered. If an item is not applicable, indicate so by writing "N/A" in blank. Your Proof of Claim will be returned to you if any items are left blank. Please review the entire form for completion prior to mailing.

3. If you need additional space to fully answer any question, please do so on a separate sheet of paper and attach to your Proof of Claim.

4. You must attach to the Proof of Claim documents or evidence supporting your proof of loss. FAILURE TO PROVIDE SUFFICIENT DOCUMENTS OR EVIDENCE SUPPORTING YOUR CLAIM IS GROUNDS FOR DENIAL THEREOF. The Liquidator reserves the right to require such other information as may be deemed necessary.

5. You have an ongoing duty to supplement your Proof of Claim with supporting documentation as additional information is received. This requirement includes notice of any change of address.

6. The Proof of Claim must be signed by the Claimant who is named in Part 1, or by a representative of the Claimant who has knowledge of the matters set forth in the Proof of Claim and in any accompanying statement and supporting documents.

7. All Proofs of Claim must be received by December 15, 2016. The Liquidator is not responsible for undelivered mail.

8. The Liquidator recommends that you keep a copy of the completed Proof of Claim for your records.

9. The Proof of Claim number should be attached to all future correspondence, amendments, or attachments to ensure proper identification.

## GENERAL INFORMATION

After all claims have been allowed, disallowed or estimated, the Liquidator will seek Court approval to begin making distributions to the approved claimants from the assets of the Company.

If you have any questions about the Proof of Claim procedure, you may call (844) 717-7334.

For more information, please visit www.cca.hawaii.gov/ins/.