PROOF OF CLAIM ("POC") IN THE MATTER OF:

KENTUCKY HEALTH COOPERATIVE, INC. ("KYHC")

READ INSTRUCTIONS ON REVERSE CAREFULLY BEFORE COMPLETING THIS FORM
PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY
POC RECEIVED DATE:

CLAIM NO.

CLAIMANT NAME AND ADDRESS

Name

Address

City State Zip

If applicable:
Policy No.:

Insured:

Date of Claim or Invoice

An Attorney is not required to complete this form. However, if one assisted you with this claim, please provide CLAIMANT'S ATTORNEY NAME AND ADDRESS

*To participate in any distributions on timely claims, all of your claims must be received by the Liquidator on or before the filing **Deadline of October 15, 2016**. No persons having a contingent claim against KYHC shall participate in any distribution of assets unless such claims are received by the Liquidator on or before the Claim Filing **Deadline of October 15, 2016.**

EACH PROOF OF CLAIM MUST HAVE ATTACHED ALL SUPPORTING DOCUMENTATION OR REFER TO DOCUMENTATION PREVIOUSLY FILED WITH KYHC TO BE CONSIDERED.

CHECK EACH APPLICABLE BASIS OF YOUR CLAIM AND LIST EACH AMOUNT IN THE FAR RIGHT COLUMN:

POLICYHOLDERS / INSUREDS:

- ☐ Unpaid benefits arising under the coverage of a KYHC policy or contract. $.
- ☐ Unearned or refund premiums related to a KYHC policy. $.

CLAIMANTS (Other than Policy holders / Insureds):

- ☐ U.S. Government claims. $.
- ☐ Secured claim. $.
- ☐ Salary or wages for services performed. $.
- ☐ Governmental entity claim for penalties or forfeitures. $.
- ☐ Unpaid legal or professional expenses. $.
- ☐ Unpaid commissions or general creditor invoices. $.
- ☐ All other claimants (On a separate sheet describe nature, amount and consideration related to each claim). $.

TOTAL AMOUNT OF CLAIM $.

Do you assert this claim is entitled to priority under KRS 304.33-370(1)(a)(5)? ☐ Yes ☐ No. If yes, identify the applicable subsection Of KRS 304.33-430 and reason for the priority amount. Use separate sheets as needed.

Describe any prior payments made on the debt:

Are there set-offs, counterclaims or defenses to the debt? ☐ Yes ☐ No. If yes, describe here: Use separate sheets as needed

Is there security for the debt? ☐ Yes ☐ No. If yes, describe the underlying security and its estimated current value:

Use separate sheets as needed.

STATUS OF CLAIM:

☐ Claim is based on a court judgment or settlement, dated: , (attach judgment or agreement if not previously provided to KYHC).

☐ Claim is currently pending in court (provide details and documentation or reference items previously provided to KYHC.

☐ Claim has not been filed in court.

Undersigned subscribes and affirms as true as follows in filing this claim: That he/she has read the foregoing Proof of Claim and knows the contents thereof; that this claim is justly owing to claimant; that there are no setoffs, counterclaims or defense to the claim, except as those noted above and that the matters set forth in any accompanying documents are true to the best of his/her knowledge and belief.

Sworn by me this

NAME OF CLAIMANT (Please print or type)

day of , 2016.

DATE SIGNED

Signature of Individual, Partner or Officer

Home Telephone ( )

E-mail:

CLAIMS NOTICE

By Order of the Franklin Circuit Court, all persons who may have claims against Kentucky Health Cooperative, Inc. ("KYHC") shall present the same to the Liquidator by **the claims bar date of October 15, 2016** through a proof of claim. A proof of claim shall consist of a statement in writing, signed by the claimant, setting forth the claim, the consideration therefor, and whether any, and if so, what security are held therefor, and whether any, and if so, what payments have been made thereon, and that the sum claimed is justly owing from the company to the claimant. Whenever a claim is founded upon an instrument in writing, such instrument, unless lost or destroyed, shall be filed with the proof of claim, unless such was previously filed with the company. If such instrument is lost or destroyed, a statement of such fact and of the circumstances of such loss or destruction shall be filed under oath with the claim.

Health care providers should NOT use this form. Claims for healthcare services must be submitted as they have been to KYHC in the normal course of business for processing. All claims must be submitted by **October 15, 2016**. Agents and brokers DO NOT need to file this form for unpaid commissions UNLESS they dispute the amount owed them as reflected on the books and records of KYHC. Notice of the commission amount owed but unpaid will be sent to agents and brokers by the Liquidator by no later than March 15, 2016.

INSTRUCTIONS

Enlisting the help of an attorney is not required. However, if your claim is completed and/or submitted on your behalf by an attorney, please provide their contact information. If your claim is for policy benefits, please provide details. Attach copies (**do not send original documents**) of supporting documents to your proof of claim. If the documents are voluminous, attach a summary. If the documents are not available, please explain. If you have other types of claims against the company provide a brief explanation of the claim and the amount claimed.

You must sign the Proof of Claim form. Please retain a copy for your records and mail the original of the form to:

Kentucky Health Cooperative, Inc.
Jeff Gaither, Special Deputy Liquidator
9700 Ormsby Station Road, Suite 100
Louisville KY 40223

CHANGE OF ADDRESS

If you move after you send in your claim form, you must provide us with your new address. Failure to do so may result in a loss of rights to obtain a distribution on your claim or to object to a denial in whole or in part of your claim.

GENERAL INFORMATION

Properly submitted health care claims (including all claims already filed) by health care providers will be considered sufficient to establish a claim with the Liquidator of KYHC for health care services without the need to file a formal Proof of Claim.

Claims presented against KYHC will be reviewed by the Liquidator in accordance with KRS 304.33. The Liquidator will either approve the claim as filed or shall deny the claim in whole or in part. A written notice of approval or denial in whole or in part will be given to the claimant or counsel. Whenever the Liquidator denies the claim in whole or in part and the claimant objects within 60 days to all or any portion of the contested amount, the contested claim shall be resolved in accordance with KRS 304.33-430.

When all claims against the company are liquidated and approved by the Court, claims will be paid based on available general assets. The amount of payment will depend on the percentage of total assets to total claims in each particular claims class. This process will take a number of months after the October 15, 2016 deadline for filing claims has passed.

The Liquidator's acceptance of this Proof of Claim form is not intended to nor does it constitute any waiver or relinquishment by the Liquidator of any defense, setoff or counterclaim that he may have against any person, entity or governmental agency.