PROOF OF CLAIM AND NOTICE OF ABSOLUTE BAR DATE
Coordinated Health Mutual dba InHealth Mutual
ABSOLUTE BAR DATE AND CLAIMS FILING DEADLINE: December 31, 2017

FOR OFFICIAL USE ONLY TO BE FILLED IN AT A LATER DATE	
Date Postmarked:	Policy #:
Date Received:	Liquidator Allowed Amount:
RCN Assigned:	Liquidator Denied Amount:

If you do NOT have a claim against Coordinated Health Mutual, Inc. dba InHealth Mutual ("InHealth") or had your claim(s) paid in full by the guaranty fund (OLHIGA), no action is required by you. If you have a claim, you must fill out this form according to the instructions on the back and return to the Liquidator no later than **December 31, 2017**. Failure to complete and return this form to the Liquidator by **December 31, 2017** may result in your claim being denied in full or in part. Please submit **all** documentation that supports your claim. If your claim consists of multiple invoices, please provide an itemization table with your submission.

CLAIMANT INFORMATION: PLEASE PRINT OR THIS SECTION

Name or Business:					
Address 1					
Address 2					
City		**ST**		**Zip**	-

Date of Birth	/ /	**If you receive a distribution in this liquidation, will it be considered income for you?**	☐ **Yes** ☐ **No**	**If yes, you must submit a W-9 Form. Go to: www.irs.gov**
Policy No:		**Insured:**		**Date of Claim or Invoice:**

Email Address:	**Daytime Phone:** (_____) ______-________
Total Amount of Claim: **(Amount must be documented including: payments made on the debt, if any; that the sum claimed is justly owing and there is no setoff, counterclaim, or defense to the claim. See back of page for instructions)**	**$** __________________.______
An Attorney is not required to complete this form. However, if one assisted you with this claim, please provide Name and Address:	Name: Address: City/State/Zip:

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 claim the subject of legal action?________ If yes, list court and case number: _______________________________________

List all parties and their attorneys:____

c. Is this claim contingent or unliquidated? If yes, explain:____

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

Type of Claim:	
Secured Claim (A secured claim is any claim secured by a mortgage, trust, deed, security agreement, etc., additional documentation of security interest must be provided)	☐ **Yes** ☐ **No**
Policyholder Loss or Unearned Premium Claims	☐ **Yes** ☐ **No**
Federal Government Claim	☐ **Yes** ☐ **No**
Employee Claim (Maximum $1000)	☐ **Yes** ☐ **No**
General Creditor Claim	☐ **Yes** ☐ **No**
State and Local Government Claim	☐ **Yes** ☐ **No**
All Other Claim Types Not Listed	☐ **Yes** ☐ **No**

I swear or affirm that I am the claimant referenced in the mailing address on this form and/or am authorized to sign this form on the claimant's behalf. I further swear under penalty of law that all information contained on this form as well as all attachments are true and correct to the best of my knowledge and that the sum claimed is justly owing from the insurer.

X____ ___/___/___ ____

Signature of/for Claimant **Date Signed** **Printed Name of Person Signing & Title (if signing for business)**

Proof of Claim Form General Instructions

1. The Proof of Claim must be typed or legibly printed in ink. **You must sign the Proof of Claim.** Do not file a Proof of Claim unless you are aware of a specific claim and can factually support it. If you do not have a claim at this time, you should keep the Proof of Claim and submit it prior to the Absolute Final Bar Date, together with supporting documentation, should you become aware of a claim. IF YOU FAIL TO ADEQUATELY DESCRIBE AND DOCUMENT YOUR CLAIM, YOUR PROOF OF CLAIM MAY BE REJECTED OR DENIED.

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 may 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. Examples of necessary evidence include contracts, invoices, receipts, etc. FAILURE TO PROVIDE SUFFICIENT DOCUMENTS OR EVIDENCE SUPPORTING YOUR CLAIM MAY RESULT IN DENIAL OF YOUR CLAIM.

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

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.

7. All Proofs of Claim must be postmarked no later than **December 31, 2017**. The Liquidator is not responsible for undelivered mail.

8. **POLICYHOLDERS**-The Ohio Life and Health Insurance Guaranty Association will be covering all eligible claims for healthcare services under the provisions of InHealth insurance policies, subject to guaranty association statutory limits, terms and conditions of coverage**. Claims for healthcare services should be submitted by you or your healthcare providers for processing by the guaranty association in the normal course of business and DO NOT require the filing of a Proof of Claim.** Policyholders are responsible for deductible and co-pay amounts due under their policies.

9. **AGENTS/BROKERS**- Agents and Brokers **DO NOT** need to file this form for unpaid commissions **UNLESS** they dispute the amount owed to them as reflected on the statement of commissions provided by the Liquidator. Notice of the commission amount owed but unpaid was previously sent to agents and brokers by the Liquidator.

10. **PROVIDERS**- All claims for healthcare services should be presented by way of currently established procedures for processing in the normal course of business no later than **December 31, 2017**. Claims presented after December 31, 2017 will not be paid. Healthcare providers **SHOULD NOT** use the proof of claim form for any health care related claims.

Certified Mail: It is recommended that you return the Proof of Claim to the Liquidator using Certified mail, return receipt requested, to prove delivery of this form. To be considered timely, your Proof of Claim must be properly completed and either mailed and postmarked no later than **December 31, 2017**.

Once you have completed and signed the Proof of Claim (and the W-9 Form, if applicable), make a copy for your records and return the form with all supporting documentation to the following address:

Coordinated Health Mutual, P.O. Box 133, Farmington, CT 06034.

If you have a question regarding the Proof of Claim that is not answered in the instructions above, please call:
1-800-580-8502 Monday-Friday 8am-5pm

For general information regarding the InHealth liquidation, please go to: **www.insurance.ohio.gov or www.inhealthohio.org**

After all claims against the company are evaluated and approved by the Court, claims will be paid based on available funds. The amount of payment will depend on the percentage of assets to total claims, as well as the priority class of your claim. The Liquidator will not know the percentage that can be paid on any individual claim until all claims are evaluated and assets converted to cash. This process may take a number of years after the deadline for filing claims has passed.

<u>NOTICE OF ABSOLUTE BAR DATE AND CLAIMS FILING DEADLINE</u>

On May 26, 2016, Coordinated Health Mutual, Inc., dba InHealth Mutual ("InHealth") was determined to be insolvent and ordered liquidated by the Court of Common Pleas, Franklin County, Ohio. Pursuant to the terms of the liquidation order, some InHealth policies remained in effect until December 31, 2016. No InHealth policies were in force after December 31, 2016. The Court ordered all persons who may have claims against InHealth to present the same to the Liquidator by **the claims bar date of December 31, 2017** through a proof of claim. The proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable: the particulars of the claim including the consideration given for it; the identity and amount of the security on the claim; the payments made on the debt, if any; that the sum claimed is justly owing and that there is no setoff, counterclaim, or defense to the claim; any right of priority of payment or other specific right asserted by the claimants; a copy of any written instrument which is the foundation of the claim; the name and address of the claimant and the attorney who represents him, if any.

<u>Healthcare Providers</u>
Health care providers should NOT use this form. Claims for healthcare services must be submitted as they have been in the normal course of business for processing. **<u>All claims must be submitted by December 31, 2017 or they will be considered untimely.</u>**

<u>Agent or Broker</u>
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 InHealth. Notice of the commission amount owed but unpaid was previously sent to agents and brokers by the Liquidator.

<u>Federal Government Claims</u>
The Liquidator requests that any agency of the Federal Government utilize a proof of claim form and file their claim by the claims filing deadline to expedite the payment of claims to lower priority claimants.

<u>Employee Claims</u>
Employees with claims up to $1,000 for services performed within 1 year of the date of liquidation may file a proof of claim form. An employee with a claim in excess of $1,000 or a claim for an expense reimbursement should file a General Creditor claim on a separate proof of claim form for the amount in excess of $1,000. Officers and Directors may not file an Employee Claim and must file a General Creditor proof of claim form.

<u>General Creditor</u>
General Creditors of all types are required to file a proof of claim form for any type of claim.

<u>IMPORTANT INFORMATION:</u> THE INFORMATION YOU PROVIDE ON THIS PROOF OF CLAIM FORM MAY BE SHARED WITH A THIRD PARTY FOR THE PURPOSE OF EVALUATING YOUR CLAIM OR OTHER INTERNAL LIQUIDATION OPERATIONS. THE LIQUIDATOR BY CONTRACT REQUIRES ANY THIRD PARTY CONTRACTOR TO MAINTAIN CONFIDENTIALITY REGARDING THE PERTINENT INFORMATION IN ITS POSSESSION.