

WINhealth Partners

In Liquidation (the "Company")
1200 E. 20th Street
Cheyenne, WY 82001

PROOF OF CLAIM

District Court of the State of Wyoming
First Judicial District
Docket No. 184-929

PLEASE READ ALL INSTRUCTIONS CAREFULLY BEFORE COMPLETING FORM

DEADLINE FOR FILING PROOF OF CLAIM IS January 2, 2017

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		<i>*WINhealth Partners liabilities fixed as of January 12, 2016</i>
<input type="checkbox"/> <u>Type of Claim</u> <input type="checkbox"/> Policyholder <input type="checkbox"/> General Creditor <input type="checkbox"/> Other	<u>Amount of Claim</u> \$ _____ \$ _____ \$ _____	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: _____ _____		

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 set offs or counterclaims thereto except as above stated. Invalid without signature and seal of Notary Public.

Claimant Signature _____ Date Signed _____

Print Name _____

Title or Official Capacity (if any) _____

Witness my hand and official seal _____

Signature and seal of Notary Public

Return your completed form to:

WINhealth Partners
ATTN: Proof of Claim
1200 E. 20th Street
Cheyenne, WY 82007

IMPORTANT NOTICE

If you have a change of 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.**
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 postmarked no later than January 2, 2017. The Receiver is not responsible for undelivered mail.
8. The Receiver 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 Conservator 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 (307) 773-1300.

For more information, please visit our website at www.winhealthplans.com. Alternatively, visit www.rsgca.org and look in the 'Companies' section for WINhealth Partners.