PROOF OF CLAIM FORM AND NOTICE OF ABSOLUTE BAR DATE

Paramount Insurance Company

DATE OF LIQUIDATION: January 9, 2019

ABSOLUTE BAR DATE AND CLAIMS FILING DEADLINE: December 31, 2019

<Claimant Name>
<Address Line 1>
<Address Line 2>
<City>, <State> <Zip>

Receiver Claim No. (RCN): <RCN>
Policy No.: <POL#>
Insured Name: <INSD NAME>
Claimant Name: <CLMT NAME>

If you do NOT have a claim against Paramount, no action is required by you. If you have a claim, you must fill out this form according to the instructions beginning on page three of this form and return pages one and two of the form to the Receiver no later than the absolute bar date and claims filing deadline indicated above. Failure to complete and return pages one and two of this form to the Receiver by the claims filing deadline may result in your claim being denied. Please submit **all** documentation that supports your claim. If your claim consists of multiple invoices, you must provide an itemization table with your submission. Please refer to the instructions included with this form.

CLAIMANT INFORMATION: PLEASE COMPLETE THIS SECTION

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

If you receive a distribution in this liquidation, will it be considered income for you?	☐ **Yes**	**If yes, you must also submit a W-9 Form with your Proof of Claim form.** **Go to:** www.irs.gov
Policy No./ Member No./Claim No.:	**Insured:**	**Date of Claim or Invoice:**
Email Address:		**Daytime Phone:**
Total Amount of Claim: $ _____ (see enclosed instructions) **Types of Claims are defined on page 2 of this form.**		

An Attorney is not required to complete this form. However, if one assisted you with this claim, please provide Name and Address:	Attorney Name: n/a
	Address:
	City/State/Zip:

a. If you have received any payments on the claim for which you are filing this proof of claim from any source, list the total amount received $_____ and identify all sources: _____

b. Are you are eligible or will you become eligible for Medicare within the next three years? _____

c. If this claim is the subject of legal action, list court and case number: _____

List all parties and their attorneys: _____ _____

d. If this claim is contingent or unliquidated, please provide details: _____

e. Is this a "master claim" for multiple underlying claims: _____ _____ If yes, refer to the claim filing instructions for additional instructions.

f. If you claim any right of priority of payment, please provide details: _____ _____

_____

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
The portion of a Policy or Third-Party Liability Claim (A policy claim is a claim against the policy by an insured. A third-party liability claim is one presented against the policy by someone who is not an insured under the policy. A policy claim can be for damages or return of premium.)	☐ Yes ☐ No
Claims of Federal Government	☐ Yes ☐ No
Employee Claim ($500 Maximum)	☐ Yes ☐ No
State Government Claim	☐ Yes ☐ No
All Other Claim Types Not Listed (If making a claim of this type, please describe on a separate page and provide a copy of all documentation supporting the claim)	☐ Yes ☐ No

I swear or affirm that I am the claimant referenced on the line marked "Name or Business Name" 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_____ ____/____/_____ **x _____**

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

IMPORTANT: For your proof of claim form to be accepted you must return pages 1 – 2 completed with signature and a W-9, if applicable.

FOR OFFICIAL USE ONLY	
Date Postmarked:	POC Timely Filed:
Date Received:	POC Proper: