For Official Use Only:

Claim No: _________

STATE OF ALABAMA DEPARTMENT OF INSURANCE
PHYSICIANS CASUALTY RISK RETENTION GROUP, INC.
IN LIQUIDATION
CIRCUIT COURT OF MONTGOMERY COUNTY, AL
PROOF OF CLAIM

This Proof of Claim must be completed, signed under oath, and sent by First Class Mail to **Ryan Donaldson, Receiver, Physicians Casualty Risk Retention Group, Inc., Post Office Box 303353, Montgomery, AL 36130-3353, NOTICE: All Proof of Claims should be POSTMARKED ON OR BEFORE December 10, 2020 OR THE CLAIM MAY BE FOREVER BARRED DUE TO UNTIMELY FILING.**

PLEASE READ THE ACCOMPANYING NOTICE AND INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM. Mark "NA" or "Not Applicable", where appropriate. PLEASE TYPE OR PRINT. A SEPARATE PROOF OF CLAIM SHOULD BE COMPLETED AND FILED FOR EACH CLAIM.

Policyholder Name: ____________________
Policy Number: ____________________

You are making this claim as (mark one):
Individual ☐ Corporation ☐ Partnership ☐ Agent ☐ Loss under policy ☐ Suppliers ☐
General Creditor ☐ (Attorney fees, Consultants, Cedants, Venders, Landlords, & Reinsurers)
Unearned premium refund ☐ (Portion of paid premium not earned due or retro or audit adjustments)
Broker ☐ Employee ☐ Other ☐ Please explain:
____
____

Please set forth the name, address and phone number of the claimant:
Claimant Name (As it appears on contract): ____________________
Point of contact if different from claimant: ____________________ Phone: ____________________
Street Address: ____________________
City____________________ State_____ Zip ___________ Cell: ____________________
Email Address ____________________

This claim is filed as a (n) unsecured ☐ secured ☐ claim. (Mark one.)
Total Amount Claimed $ ____________________ Date claim was incurred____________________

Explanation of Claim.
Please attach documentation to support claim amount. Attach additional sheets if necessary.
1. The consideration for this debt (or ground of liability) is as follows:
____
____

2. If this claim is founded on a written instrument, please attach a copy of such written instrument or if it cannot be attached please set forth the reason thereto.
____
____

OVER (COMPLETE OTHER SIDE)

3. If you have received compensation for your claim, please state the amount of the payment received and the identity of the payer

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____

4. State whether this claim is subject to any set off, counterclaim or defense:

____

____

5. Please set forth the identity of amount of security for the claim, if any (evidence of the security interest and its perfection should be attached):

____

____

6. Please set forth any right of priority of payment, or other specific right, you believe you may have: and the legal basis for same.

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7. If you have been sued or have instituted suit in connection with the claim, indicate the court, term, case number, date filed, whether judgment has been entered, and the date of judgment, if any: Provide a copy.

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If an attorney represents you in this claim, please give the following information:
Attorney's name ______________________ Law Firm______________________
Address ____
City ______________ State _____ Zip ______Phone______________________
Email Address____

The undersigned subscribes and affirms under penalties of perjury that the facts stated in this Proof of Claim to be filed in the liquidation proceeding of Physicians Casualty Risk Retention Group, Inc. to the best of my knowledge and belief, the statements and attached supporting documents in this claim are true and correct; that no payment of or on account of the aforesaid claim has been made except as above stated; that claimant has no knowledge of anyone else filing a claim on behalf of claimant; that there are no offsets, counterclaims or defense thereto except as above stated; and that claimant is not a secured creditor or claimant has no security interest, except as above stated.

Claimant's Signature ______________________ Title, if applicable______________________

Print Name ____

Telephone No. __________________ Social Security or Tax ID# ______________________

Subscribed and sworn to before me, a Notary Public this _____ day of ______________, 20_______.

______________________________ ______________________________
Signature of Notary Public Printed Name of Notary Public

I am a resident of ________________County, ____________ (State).

SEAL My commission expires ____________.

CLAIM(S) MUST BE POSTMARKED ON OR BEFORE DECEMBER 10, 2020