PROOF OF CLAIM

Colorado Health Insurance Cooperative, Inc. ("Colorado HealthOP")
In Liquidation (the "Company")
PO Box 26894
San Francisco, CA 94126-6894

District Court of the City and County of Denver
Case No. 2015CV33680

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* **Colorado HealthOP liabilities fixed as of January 4, 2016*

Type of Claim	Amount of Claim
☐ Policyholder	$ _____
☐ General Creditor	$ _____
☐ Medical Provider	$ _____
☐ Insurance Producer	$ _____
☐ Other	$ _____

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: _____

e. Do you claim any right of priority of payment? If yes, please 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 setoffs, counterclaims, or defenses thereto except as above stated.

Claimant Signature_____ **Date Signed** _____

Print Name_____

Title or Official Capacity (if any) _____

Return your completed form to:

Colorado HealthOP
ATTN: Proof of Claim
PO Box 26894
San Francisco, CA 94126-6894

IMPORTANT NOTICE

If you change your 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 (720) 627-8900.

For more information, please visit visit www.rsgca.org and look in the 'Companies' section for Colorado Health Insurance Cooperative, Inc.