

**PROOF OF CLAIM**  
**STATEWIDE INSURANCE COMPANY IN REHABILITATION**

\_\_\_\_\_  
POC Number  
(Official Use)

**DEADLINE FOR FILING CLAIMS IS FEBRUARY 28, 2006**

Please read the cover letter carefully before completing both sides of this Proof of Claim form. Each section must be fully completed.

1. CLAIMANT'S NAME: \_\_\_\_\_

2. MAILING ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

3. TEL. NO. (Daytime): \_\_\_\_\_ 4. FAX NO.: \_\_\_\_\_

5. E-MAIL ADDRESS, if any: \_\_\_\_\_ 6. DATE OF LOSS: \_\_\_\_\_

7. STATEWIDE INSURED'S NAME: \_\_\_\_\_

8. CLAIM NO: \_\_\_\_\_ 9. POLICY NO.: \_\_\_\_\_

**10. CLAIM IS FOR (Check "X" or specify below):**

- A. ( ) Third Party Tort Claim Against Statewide Insured.
- B. ( ) Uninsured/Underinsured Claim of Statewide Policyholder.
- C. ( ) Subrogation Claim or Claim for Contribution or Indemnification.
- D. ( ) Vendor/ Other General Creditor
- E. ( ) Other---Please explain the nature of the claim below: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

11. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. AMOUNT OF YOUR CLAIM. \$ \_\_\_\_\_.

13. Is there OTHER INSURANCE which may cover this claim? YES ( ). NO ( ). If YES, give name of the insurer and policy number.  
\_\_\_\_\_

14. Are you REPRESENTED BY AN ATTORNEY: YES ( ). NO ( ). If YES, provide attorney's name, address, and telephone number.  
\_\_\_\_\_  
\_\_\_\_\_

15. Has a LAWSUIT or other LEGAL ACTION been instituted by anyone? YES ( ). NO ( ). If YES, provide the following:

A. COURT WHERE FILED: \_\_\_\_\_

B. DATE FILED & DOCKET NUMBER: \_\_\_\_\_

C. PLAINTIFF(S): \_\_\_\_\_

D. DEFENDANT(S): \_\_\_\_\_  
\_\_\_\_\_

SEE REVERSE

**IMPORTANT: This Proof of Claim must be sworn to before a Notary Public or person authorized to administer oaths.**

**I affirm under the penalties for perjury that the facts stated in this Proof of Claim to be filed in the rehabilitation proceeding of Statewide Insurance Company in Rehabilitation are true and correct.**

STATE OF \_\_\_\_\_ ) \_\_\_\_\_  
Claimant (sign on line above)

Print Name: \_\_\_\_\_

COUNTY OF \_\_\_\_\_ ) \_\_\_\_\_

Title or Official Capacity of Signatory for Company or Corporation

Subscribed and sworn to before me, a Notary Public this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_.

\_\_\_\_\_  
Signature of Notary Public

\_\_\_\_\_  
Printed Name of Notary Public

I am a resident of \_\_\_\_\_ County, \_\_\_\_\_.

My commission expires \_\_\_\_\_.

\*\*\*\*\*  
**DEADLINE FOR FILING CLAIMS IS**  
\*\*\*\*\*  
**February 28, 2006**

**RETURN TO:**

**Statewide Insurance Company in Rehabilitation  
841 Silver Lake Blvd., Suite 205  
Dover, DE 19904**

## *Statewide Insurance Company in Rehabilitation*

### **INSTRUCTIONS FOR COMPLETING PROOF OF CLAIM**

TO: STATEWIDE'S POLICYHOLDERS, THIRD PARTY CLAIMANTS,  
AND OTHER POTENTIAL CREDITORS OF THE  
ESTATE OF STATEWIDE INSURANCE CO. IN REHABILITATION

DATE: NOVEMBER 30, 2005

The Honorable Matthew Denn, Insurance Commissioner of the State of Delaware, in his capacity as Receiver (the "Receiver") of Statewide Insurance Company in Rehabilitation ("Statewide") has sought the entry of an Order establishing a Bar Date of February 28, 2006, for the filing of claims against Statewide, pursuant to a Plan of Rehabilitation of Statewide. A hearing on the Receiver's Petition to have the Court approve the Plan of Rehabilitation and establish the Bar Date of February 28, 2006, will be held on Friday, January 13, 2006 at 10:00 a.m., at the Court of Chancery of the State of Delaware in and for New Castle County, New Castle County Courthouse, 500 North King Street, Wilmington, Delaware 19801. If the Court approves the Plan of Rehabilitation and establishes the Bar Date of February 28, 2006, any and all claims not specifically exempted by the Plan of Rehabilitation are required to file a proof of claim with the Receiver on or before the Bar Date of February 28, 2006. Any claimant who fails to file a proof of claim as required by the Plan of Rehabilitation and the Court's Order shall be forever barred from sharing in the assets of the Statewide estate.

Each section of the proof of claim form should be completed. If a section is not applicable, please so state. A separate proof of claim form should be completed for each claim against the estate. (If you believe you have more than one claim, you should photocopy the proof of claim form for the additional claims.) The proof of claim form must be completed in accordance with the instructions, must be signed **under oath**, and must be returned to the address indicated on the proof of claim form on or before the Bar Date of **February 28, 2006**, or your claim will be barred from sharing in any distributions of assets from the Statewide estate. All interested parties are encouraged to complete and send in their proof of claim forms as soon as possible. The completed proof of claim form must be RECEIVED by the Statewide estate on or before February 28, 2006. The completed Proof of Claim form should be addressed to:

STATEWIDE INSURANCE COMPANY IN REHABILITATION  
841 Silver Lake Boulevard, Suite 205  
Dover, Delaware 19904  
Telephone: (302) 735-1800

Proofs of Claim will not be accepted by facsimile or by e-mail. The original signed and notarized proof of claim form must be submitted to the Receiver.

Please note that this proof of claim process applies only to claims against the Statewide Insurance Company in Rehabilitation, not to any claims against its parent company, Statewide Insurance Holding Company. Any claim you believe you have against that company should be directed to that company, not to the Receiver of Statewide.