

**OHIO LIQUIDATION PROCEEDING  
REGARDING  
THE PHYSICIANS' ASSURANCE CORPORATION**

Liquidator's No.:
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**PROOF OF CLAIM**

**ABSOLUTE FINAL BAR DATE FOR FILING OF PROOF OF CLAIM IS MARCH 18, 2011**

A Liquidation Proceeding has been opened in Ohio, pursuant to Chapter 3903, in the Franklin County, Ohio Court of Common Pleas, Case No. 09CVH 08 12492, to consider and adjudicate claims under Ohio law as a result of the insolvency of The Physicians' Assurance Corporation ("TPAC").

**IF YOU WERE A MEMBER/ENROLLEE OF TPAC, OR A HEALTH CARE PROVIDER WHO RENDERED SERVICES TO A MEMBER/ENROLLEE OF TPAC, AND YOU HAVE ALREADY RECEIVED PAYMENT IN FULL ON YOUR CLAIM FROM A GUARANTY ASSOCIATION, THEN YOU DO NOT NEED TO FILE A PROOF OF CLAIM.**

If, however, you have any outstanding claims against TPAC, then you must fill out this form completely and return it to **The Physicians' Assurance Corporation, In Liquidation, no later than March 18, 2011, which is the Absolute Final Bar Date for filing a Proof of Claim in the TPAC liquidation**, by one of the methods provided on page 2.

FAILURE TO HAVE THIS FORM COMPLETED, MAILED AND POSTMARKED, FAXED, OR EMAILED ON OR BEFORE **MARCH 18, 2011**, WILL AFFECT YOUR LEGAL RIGHTS AND WAIVE AND BAR ANY CLAIM THAT YOU MIGHT OTHERWISE HAVE.

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**Please file only one (1) claim per Proof of Claim form. If you have more than one (1) claim against TPAC, you may file as many separate Proofs of Claims as necessary to submit each of your individual claims. Attach all documents supporting your claim.**

**PLEASE PRINT OR TYPE THIS SECTION**

1. Name: \_\_\_\_\_ 2. Daytime Phone Number  
\_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

3. Email address (optional): \_\_\_\_\_

4. Address:  
\_\_\_\_\_  
Street Address City State Zip Code

5. Give a brief explanation of the facts and basis surrounding your claim, including the consideration on which it is based. Attach all documents which are the foundation of or otherwise provide support for the claim, including the appropriate medical billing forms if your claim is one for unpaid medical care, and identify the date on which your claim arose against TPAC (use additional pages if necessary and attach all documentation supporting your claim).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Identify the amount of the claim, the identity and amount of security on the claim, if any, payments made on the claim to date, if any, and the right of priority of payment or other specific rights being claimed, if any. (Use additional pages if necessary.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Social Security or Federal Employer ID No.: \_\_\_\_\_

Provider ID No.: \_\_\_\_\_

Group ID No.: \_\_\_\_\_

Employee ID No.: \_\_\_\_\_

Employer Name: \_\_\_\_\_

8. By signing this Proof of Claim (this form **MUST BE SIGNED**), the Undersigned verifies that the sum claimed is justly owing, that there is no set-off, counterclaim, or defense to the claim, and that the matters set forth in any accompanying documents are true to the best of his/her knowledge and belief.

Name & Address of Attorney (if any):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Printed** \_\_\_\_\_  
**Title (if applicable)** \_\_\_\_\_  
**Date Signed:** \_\_\_\_\_

**This Proof of Claim form with supporting documentation must be returned to TPAC no later than the Absolute Final Bar Date of MARCH 18, 2011, by one of the following methods:**

- MAIL by depositing it in the United States mail, first class postage prepaid, **postmarked by March 18, 2011**, addressed to the attention of:  
The Physicians' Assurance Corporation, In Liquidation  
c/o Office of the Ohio Insurance Liquidator  
50 West Town Street, 3<sup>rd</sup> Floor, Suite 350  
Columbus, Ohio 43215-4197
- FAX to (614) 487-9418 so that it is successfully received by the Liquidator **no later than MARCH 18, 2011**; or
- EMAIL to [TPAC@OHLIQ.com](mailto:TPAC@OHLIQ.com) so that it is successfully received by the Liquidator **no later than MARCH 18, 2011**.

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**To be Completed by Liquidator:**

**Claim I.D. #:** \_\_\_\_\_

**Postmarked Date:** \_\_\_\_\_

**Received (Mail/ Fax /Email):** \_\_\_\_\_

**NOTE:** This Proof of Claim form is posted on the Liquidator's website, [www.ohliq.com](http://www.ohliq.com), in a downloadable Portable Document Format (PDF). You may print off additional claim forms from the website, or call the Liquidator's Office at (614) 487-9200 to request that an additional Proof of Claim form be mailed to you.