**PROOF OF CLAIM**

**OMNI DENTAL ASSOCIATES, INC. (OMNI) IN LIQUIDATION**

**ALL CLAIMS MUST BE POSTMARKED BEFORE THE CLAIM FILING DEADLINE OF 5:00 PM CENTRAL STANDARD TIME ON DECEMBER 15, 2014. READ CAREFULLY BEFORE COMPLETING. SEE INSTRUCTIONS ON BACK**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FOR OFFICE USE ONLY:** | | | | | | | | |
| Date Postmarked: | | | | Interested Party Name: | | | | |
| Date Received: | | | | Address: | | | | |
| Proof of Claim No: | | | | ID#: | | | Policy#: | |
| Liquidator Allowed Amount: | | Liquidator Denied Amount: | | | | Court Allowed Amount: | | |
| **CLAIMANT INFORMATION** | | | | **Claimant Please Complete – Print (black ink) or Type** | | | | |
| Name: | | | |  | | | | |
| Address: (Include City, State & Zip Code) | | | | Policy Period: | | | | |
| Home Phone: | | | | Insured: | | | | |
| Work Phone: | | | | Existing Claim No. (if any): | | | | |
| SSN or EIN: | | | | Date Claim Incurred: | | | | |
| **CLAIM INFORMATION** | All supporting documentation must be attached to Proof of Claim in order to be considered. | | | | | | | |
| Claim is for:  **Policyholder/Insured**  Claim is made for a specific loss or occurrence arising under dental coverage of the following type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other – Specify Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Claim is made for the return of unearned premium due to early cancellation (If amount is unknown, Liquidator will calculate). Amount of premium/consideration paid to date \_\_\_\_\_\_\_\_\_\_\_. Attach copies of cancelled checks or other proof of payments.  **All Other Claimants:**  Claim is made by a Dental Service Provider.  Claim is made by an attorney for unpaid legal expenses.  Claim is made by a general creditor for unpaid invoices.  Claim is made by an agent or broker.  All others: state particulars of claim, including consideration given for this claim and attach supporting documentation; including a copy of written instrument which is the foundation of the claim.  Please provide the exact amount of your claim and each component. Attach supplemental documentation, if available to support your claim.  **TOTAL AMOUNT OF CLAIM:** | | | | | | | | **Amount of Claim**  **$** |
| What payments have you received for this claim from Omni? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  What collateral or other securities do you hold? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you assert any right of priority or other specific right with respect to your claim? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **STATUS OF CLAIM** | | | | | | | | |
| Claim is based on a court judgment or settlement (attach judgment or agreement).  Claim currently pending in court (provide details and documentation).  Claim is not yet filed in court.  Claim previously reported to Omni, Date reported \_\_\_\_\_\_\_\_\_\_\_  Other Insurance is available to cover this claim. | | | | | Name and address of your attorney if any:  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_  Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **VERIFICATION** | | | | | | | | |
| The undersigned subscribes and affirms as true under penalty of perjury as follows:  I have read the foregoing Proof of Claim and know the contents thereof: that this claim of $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ against Omni Dental Associates, Inc. is justly owing to the claimant; that there is no set-off, counterclaim or defense to the claim thereto, except as above stated; that the matters set forth above and in any accompanying statements are true to my knowledge except as matters specifically stated to be alleged upon information and belief and that as to such matters, I believe them to be true; that no payment of or on account of the aforesaid claim has been made, except as stated above. | | | | | | | | |
| Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Subscribed and sworn to me this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_, 20\_\_\_\_.  Signature of Notary Public/Commissioner of Oaths  State of \_\_\_\_\_\_\_ County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  My commission expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **(Seal)** | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print or Type Name of Claimant, Partner, Officer or Legal Representative  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Individual, Partner, Officer, or Legal Representative  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title or Official Capacity  Home Phone (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Work Phone (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Social Security Number or FEIN of Claimant | | | | | |

See reverse side for mailing and other instructions

**PROOF OF CLAIM INSTRUCTIONS**

**All Claims**

The Proof of Claim (“POC”) should be completed in its entirety and all questions answered.

Please note certain instructions and requirements are contained in the POC itself. A separate form should be completed for each claim asserted against Omni Dental Associates, Inc. (Omni). Additional forms may be obtained from Claimant Services at the address set forth below. For questions that do not apply to your situation, your response should be indicated with an “NA” or “not applicable.”

If your claim is for return of premiums, you do not have to calculate the amount; however you may enter the amount, if known. You must include proof of payment of last premium.

If your claim is for policy benefits, please provide a detailed explanation, including Provider’s name. For other types of claims against Omni, provide an explanation of the claim, the amount claimed, and documentation supporting the claim. If you do not know the amount of the claim, write “unstated amount.”

You must sign the POC form and have it notarized. Please refer to the instructions in the attached “Notice” as to who should sign the claim form.

Please retain a copy for your records and mail the original to:

Claimant Services

**Omni Dental Associates, Inc. in Liquidation**

300 West Broadway Suite 215

Council Bluffs, Iowa 51503

**THE LAST DAY FOR FILING TIMELY CLAIMS AGAINST OMNI DENTAL ASSOCIATES, INC. IN LIQUIDATION IS 5:00 o’clock p.m. Central Standard Time on December 15, 2014.** Claims must be postmarked (not postage meter stamped) no later than 5:00 o’clock p.m. Central Standard Time on December 15, 2014.

You will be advised of receipt of your completed POC and your POC number. You will be notified some time thereafter of the Liquidator’s decision regarding your claim. If your claim is denied in whole or part by the Liquidator, and you dispute the Liquidator’s findings, you will have the opportunity to present your dispute to the Liquidation Court in Lancaster County, Nebraska, or a forum designated by the Court.

The Liquidator’s acceptance of the POC is not intended to, nor does it constitute, a waiver or relinquishment by the Liquidator of any defense, set-off or counterclaim which the Liquidator may have against any person, entity or governmental agency.

All claimants are requested to keep the Liquidator advised of address changes. Inquiries as to the status of your claim should be made in writing. Please identify your POC number in all correspondence to permit ease of identification and an expedited response.

Information regarding the ongoing liquidation can be requested by mail by writing to the address above, or by phone at 712-329-3622 or 712-329-3642.