On January 28, 2015, the Insurance Commissioner of the State of California ("the Commissioner") was appointed as Liquidator of SeeChange Health Insurance Company ("SeeChange" or "the Company"), pursuant to Section 1016 of the California Insurance Code, by order the Superior Court of the State of California, County of Los Angeles, Central Civil West Dept. 307, in the case captioned *Commissioner v. SeeChange Health Insurance Co.*, case no. BS152302. The liquidation order authorizes the Commissioner as Liquidator, through the Conservation & Liquidation Office, to liquidate and wind up the business of SeeChange and to act in all ways and exercise all powers necessary for the purpose of the liquidation order and the liquidation provisions of the Insurance Code.

All existing policy-related claims were transferred to the Insurance Guaranty Association (IGA) in the claimant's state. It is not necessary to file a Proof of Claim with regard to those claims as they are deemed filed. All other persons with claims or potential claims against SeeChange must file a Proof of Claim in order to preserve their claims. If you believe you have a claim against SeeChange you are required to file your Proof of Claim on this form and return the completed form to the address shown on the back of this document no later than December 31, 2015.

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, please write "N/A" in that section. 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 it to your Proof of Claim.

4. You must attach to the Proof of Claim documents or evidence supporting your claim. FAILURE TO PROVIDE SUFFICIENT DOCUMENTS OR EVIDENCE SUPPORTING YOUR CLAIM IS GROUNDS FOR REJECTION.

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 December 31, 2015. The Liquidator is not responsible for undelivered mail.

8. The Liquidator suggests you keep a copy of the completed Proof of Claim for your records.

GENERAL INFORMATION

After all claims have been approved or rejected, the Liquidator 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 (415) 676-2123 or e-mail to: SeeChangePOC@caclo.org. Please visit the website at www.caclo.org/seechange for additional information.

SEECHANGE HEALTH INSURANCE COMPANY IN LIQUIDATION

PROOF OF CLAIM

PLEASE READ ALL INSTRUCTIONS ON THE BACK OF THIS FORM CAREFULLY BEFORE COMPLETING FORM

DEADLINE FOR FILING PROOF OF CLAIM IS DECEMBER 31, 2015

Part 1 Person or Entity Making Claim (Claimant)	
Claimant Name:	
Address 1:	**Claimant Telephone**
Address 2:	**Claimant E-Mail**
City: **State:** **Zip Code:**	**SSN 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

Type of Claim	Amount of Claim
☐ Policyholder	$ _____
☐ General Creditor	$ _____
☐ 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: _____

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 set offs or counterclaims thereto except as above stated.

Claimant Signature_____ **Date Signed** _____

Print Name_____

Title or Official Capacity (if any) _____

Return your completed form to: **SeeChange Health Insurance Company Proof of Claim**
Conservation and Liquidation Office
P O Box 26894
San Francisco, CA 94126-6894

Or Email: SeeChangePOC@caclo.org

IMPORTANT NOTICE

If you have a change of address after filing your Proof of Claim you must provide us with your new address in order to receive any payment that might be due.