FLORIDA SELECT INSURANCE COMPANY IN RECEIVERSHIP
PROOF OF CLAIM FORM

***NOTICE: Please file one (1) Proof of Claim Form per claim. In the event that you intend to submit more than one (1) claim, a separate Proof of Claim Form is to be used for each specific claim you submit.**
If you have no claim, please ignore this form. In the event you wish to submit a claim, print or type your information as required below on this Proof of Claim Form:

A. BACKGROUND INFORMATION

Name/Company: _____
Date of Birth: _____
Street Address: _____
City/State/Zip Code: _____
Contact Person: _____
Contact Telephone: _____
Contact E-Mail: _____
Policy Number: _____
Policy Property Address (if different from above): _____
Premium Paid (if known): _____
Date of Loss: _____

B. CLAIMANT TYPE: (***Select One***)

- ◉ Insured
- ○ Employee
- ○ Insurance Agent
- ○ General Creditor
- ○ Person Injured/Damaged by Insured
- ○ Premium Finance Company
- ○ Accounting, Legal or other Professional Services
- ○ Other (Describe: _____)

C. TOTAL AMOUNT OF CLAIM: $ _____ (if unknown, please enter $1.00)
If you receive a distribution in the receivership will it be considered income for you? ☐ YES* ☐ NO
*If YES, you must submit a W-9 Form. Go to: **www.IRS.gov** to obtain a W-9 Form.

D. DESCRIPTION OF CLAIM (PROVIDE SPECIFIC DATES AND FACTS – YOU MAY USE A SEPARATE SHEET IF NECESSARY): _____

_____

cc _____

_____

_____

E. DOCUMENTATION: In order to evaluate your claim, we need documentation that supports your claim. All documentation in support of your claim must be submitted along with this Proof of Claim Form. Depending on the type of your claim, examples of supporting documentation include: paid medical bills, police reports, repair estimates, cancelled checks or receipts; invoices; contracts; judgments or court orders; witness statements; etc.

FAILURE TO PROVIDE ALL APPLICABLE INFORMATION ON THIS PROOF OF CLAIM FORM OR SUBMIT DOCUMENTATION IN SUPPORT OF YOUR CLAIM MAY RESULT IN THE DENIAL OF YOUR CLAIM

I swear or affirm that I am the claimant referenced on this Proof of Claim Form and/or am authorized to sign this form on the claimant's behalf. I further swear under penalty of law that all information contained on this form as well as all attachments are true and correct to the best of my knowledge. The filing of a claim in the receivership proceeding is a release of the insured to the extent of coverage provided by the insurer.

Signature of/for Claimant: _____ **Date Signed:** ___/___/____

Printed Name of Person Signing and Title: _____

***RETURN CLAIM FORM(S) POSTMARKED NO LATER THAN APRIL 12th, 2010 TO*:**
Florida Select Insurance Company, in Receivership
c/o Claims Department
P.O. Box 110
Tallahassee, Florida 32302-0110
Toll Free: (800) 882-3054
Website: www.floridainsurancereceiver.org