

COPY

IN THE CIRCUIT COURT OF THE
SECOND JUDICIAL CIRCUIT,
IN AND FOR LEON COUNTY, FLORIDA

IN RE: THE RECEIVERSHIP OF
SUNSTAR HEALTH PLANS, INC.

CASE NO.: 99-6705

BOB INZEE
CLERK CIRCUIT COURT
LEON COUNTY, FLORIDA

04 JUL 21 PM 23

FILED
CIRCUIT CIVIL DIV.

RECEIVER'S FIRST INTERIM FILED CLAIMS REPORT AND RECOMMENDATIONS
ON NON-GUARANTY ASSOCIATION CLAIMS

THE FLORIDA DEPARTMENT OF FINANCIAL SERVICES, as Receiver of Sunstar Healthplans, Inc. ("Receiver"), files herewith the Receiver's First Interim Filed Claims Report and says:

1. SunStar Health Plan, Inc., ("SunStar"), was a Florida corporation previously authorized to transact the business of a health maintenance organization in the State of Florida pursuant to Chapter 641, Florida Statutes. On February 1, 2000, this Court adjudicated SunStar insolvent and entered the Order Appointing the Florida Department of Insurance as Receiver [of SunStar] for Purposes of Liquidation, Injunction, and Notice of Automatic Stay (the "Order"). On January 7, 2003, the Florida Department of Insurance became a part of the Florida Department of Financial Services.

2. This Court has jurisdiction over the SunStar Receivership and is "authorized to make all necessary or proper orders to carry out the purposes of" the Florida Insurers Rehabilitation and Liquidation Act. Section 631.021(1), Florida Statutes.

3. In accord with the Court's Order and Section 631.182, Florida Statutes, the Receiver has compiled a First Interim Filed Claims Report (the "Report"). The Report is attached hereto in electronic form as a compact disc as Exhibit "A." For the Court's convenience, a paper copy of the summary totals from the Report is attached as Exhibit "B". The total amount of the claims in the Report is \$51,304,396.69. The total amount recommended by the Receiver is \$29,037,314.66.

4. The Report is broken down into the following four parts:

Part A- Claimant agreed with remittance amount;

Part B- Agent/Agency claims;

Part C- Subscriber/Group claims; and

Part D- Provider claims.

5. After Sunstar was placed into liquidation, the Receiver sent a Remittance Advice and a Proof of Claim form to each potential claimant. The Remittance Advice informed the potential claimants of the Receiver's calculation of the value of their potential claim. If the potential claimants wanted to file a claim in the Sunstar estate, they had to file the Proof of Claim form with the Receiver and either agree with the amount contained on the Remittance Advice, or provide some evidence of a different amount.

6. Pursuant to the terms of the Proof of Claim form, if a claimant returned the form acknowledging that they agreed with the amount contained on the Remittance Advice, that Claimant also acknowledged that the Receiver would present the recommendation to the court and the claimant waived any and all rights to any objection regarding the claim. A sample copy of a Proof of Claim form and Remittance Advice are attached as Composite Exhibit "C".

7. Part A of the Report contains the claims of Sunstar claimants that filed Proof of Claim forms and agreed with the amounts contained in their Remittance Advice. The total amount of the claims in Part A of the Report is \$7,183,548.11. The total amount recommended by the Receiver in Part A of the Report is \$6,861,227.09. For the Court's convenience, a paper copy of the summary totals from Part A of the Report is attached as Exhibit "D".

8. Part B of the Report contains the claims of Sunstar agents and agencies. The total amount of the claims in Part B of the Report is \$748,885.63. The total amount recommended by the Receiver in Part B of the Report is \$251,132.32. For the Court's convenience, a paper copy of

the summary totals from Part B of the Report is attached as Exhibit "E".

9. Part C of the Report contains the claims of Sunstar subscribers and groups. The total amount of the claims in Part C of the Report is \$1,693,463.67. The total amount recommended by the Receiver in Part C of the Report is \$139,767.77. For the Court's convenience, a paper copy of the summary totals from Part C of the Report is attached as Exhibit "F".

10. Part D of the Report contains the claims of Sunstar providers. The total amount of the claims in Part D of the Report is \$41,678,499.28. The total amount recommended by the Receiver in Part D of the Report is \$21,785,187.48. For the Court's convenience, a paper copy of the summary totals from Part D of the Report is attached as Exhibit "G".

11. Under Section 631.181(1), Florida Statutes, claimants are entitled to notice of the Receiver's recommendations on their claim and the deadline for filing objections. Sample copies of "Notice to Claimants" are attached hereto as Composite Exhibit "H."

12. Because the Claimants listed in Part A of the Report agreed with the Receiver's recommendations and waived any and all rights to any objection regarding their claim, the Receiver does not intend to send those claimants a "Notice to Claimants."

13. The Receiver recommends that its Recommendations be approved unless an objection is filed thereto within a deadline set by the Court.

WHEREFORE, the Receiver moves this Court for entry for an Order:

A. Authorizing and directing the Receiver to notify claimants listed in Parts B, C and D of the Report of the Receiver's recommendations by U.S. Mail to the last known address of such persons, as shown in the Receiver's files.

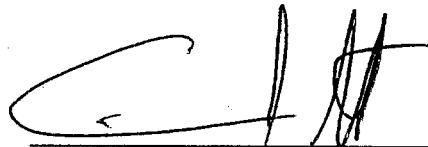
B. Authorizing the Receiver to refrain from notifying the claimants listed in Part A of the Report because those claimants have waived any and all rights to any objection regarding their claim.

C. Directing all persons who have filed claims, as herewith reported to the Court, to file any objection to the Receiver's report with the Clerk of this Court on or before 11:59 p.m. on Wednesday, September 15, 2004, and requiring that a copy of said objection be served on the Receiver.

D. Requiring any persons filing objections to submit documentation to support their claim and declaring that the Court will not consider any information or documentation submitted after the objection is filed.

E. Finally, approving the Receiver's recommendations contained in Receiver's First Interim Filed Claims Report for which no objections are filed.

DATED this 21st day of July, 2004.



ERIC S. SCOTT, Senior Attorney
Florida Bar No. 0911496
Florida Department Of Financial Services
Division of Rehabilitation and Liquidation
Post Office Box 110
Tallahassee, Florida 32302-0110
(850) 413-4414 - Telephone
(850) 488-1510 - Facsimile

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF REHABILITATION AND LIQUIDATION
 SUNSTAR HEALTHPLAN
 FIRST INTERIM FILED CLAIMS REPORT
 FILED CLAIMS SUMMARY REPORT (PARTS A THRU D)

SUMMARY TOTALS

AMOUNT CLAIMED	\$51,304,396.69
AMOUNT RECOMMENDED TO CLAIMANT	\$29,037,314.66
TOTAL NUMBER	6,387

COUNT OF CLASS 1 CLAIMS :		0	COUNT OF CLASS 6 CLAIMS :	4,348
AMOUNT CLAIMED FOR CLASS 1 CLAIMS :		\$0.00	AMOUNT CLAIMED FOR CLASS 6 CLAIMS :	
AMOUNT RECMD TO CLAIMANT FOR CLASS 1 CLAIMS :		\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 6 CLAIMS :	
COUNT OF CLASS 2 CLAIMS :		1,269	COUNT OF CLASS 7 CLAIMS :	
AMOUNT CLAIMED FOR CLASS 2 CLAIMS :		\$1,322,701.64	AMOUNT CLAIMED FOR CLASS 7 CLAIMS :	
AMOUNT RECMD TO CLAIMANT FOR CLASS 2 CLAIMS :		\$82,788.06	AMOUNT RECMD TO CLAIMANT FOR CLASS 7 CLAIMS :	
COUNT OF CLASS 3 CLAIMS :		511	COUNT OF CLASS 8 CLAIMS :	
AMOUNT CLAIMED FOR CLASS 3 CLAIMS :		\$314,848.79	AMOUNT CLAIMED FOR CLASS 8 CLAIMS :	
AMOUNT RECMD TO CLAIMANT FOR CLASS 3 CLAIMS :		\$56,979.71	AMOUNT RECMD TO CLAIMANT FOR CLASS 8 CLAIMS :	
COUNT OF CLASS 4 CLAIMS :		0	COUNT OF CLASS 9 CLAIMS :	
AMOUNT CLAIMED FOR CLASS 4 CLAIMS :		\$0.00	AMOUNT CLAIMED FOR CLASS 9 CLAIMS :	
AMOUNT RECMD TO CLAIMANT FOR CLASS 4 CLAIMS :		\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 9 CLAIMS :	
COUNT OF CLASS 5 CLAIMS :		0	COUNT OF CLASS 10 CLAIMS :	
AMOUNT CLAIMED FOR CLASS 5 CLAIMS :		\$0.00	AMOUNT CLAIMED FOR CLASS 10 CLAIMS :	
AMOUNT RECMD TO CLAIMANT FOR CLASS 5 CLAIMS :		\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 10 CLAIMS :	

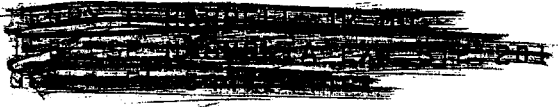
RECEIVED STATE OF FLORIDA DEPARTMENT OF INSURANCE



PROVIDER PROOF OF CLAIM FORM

TO: RECEIVERSHIP ID #
489-0000810092-00001

PROVIDER #
591479938



**PLEASE MARK ANY
ADDRESS CHANGES
ON THE MAILING
ADDRESS**

COMPANY: SUNSTAR HEALTH PLAN, INC., in Receivership
DATE OF LIQUIDATION ORDER: FEBRUARY 1, 2000
DEADLINE FOR FILING CLAIMS: 11:59 p.m., FEBRUARY 2, 2001

THIS IS NOT A BILL. You have been identified as a person who MIGHT have a claim with the above Health Maintenance Organization, SunStar Health Plan, Inc. ("SunStar"). **IF YOU HAVE A CLAIM, PLEASE USE THIS FORM.** If you do not have a claim, ignore this form.

SunStar was declared financially insolvent and is in liquidation proceedings before the Circuit Court, Leon County, Tallahassee, Florida. The court appointed the Florida Department of Insurance as the Receiver of SunStar. As such, the Receiver will be collecting and liquidating the company's assets and property. The liquidation order, and other laws, stop all proceedings against SunStar and prohibit the commencement of any new actions, including legal actions and actions taken to collect monies owed by SunStar.

THIS FORM MUST BE SIGNED AND NOTARIZED

IF YOU HAVE A CLAIM for an unpaid debt incurred prior to February 1, 2000, **YOU MUST COMPLETE, SIGN, NOTARIZE AND RETURN THIS FORM** to the Receiver before the **DEADLINE FOR FILING CLAIMS** stated above, or your claim may be barred. If you require proof that your claim has been submitted, you should submit your proof of claim form by certified mail, return receipt requested. In submitting this claim, you make a legal statement that the money you are requesting is justly owed and you have no set-off, counterclaim, or defense [Section 631.18 (2)(a)(4), Florida Statutes]. The Receiver may reject any claim that has not been submitted on this form, has not been properly and completely filled out, or has not been submitted with copies of supporting documentation (e.g. medical bills, invoices, cancelled checks, etc.). The filing of a claim in the receivership proceeding is a release of the insured to the extent of coverage provided by the insolvent company [Section 631.193, Florida Statutes].

The procedure for filing and evaluating claims in a receivership is set forth in Florida Statutes, Chapter 631, Part I. This statute establishes a system of priorities in paying claims. The Receiver will evaluate claims in order of their priority, assuming there are sufficient assets in the receivership estate [Section 631.271 Florida Statutes]. Those claims that fall in the lower priorities are paid only if there are funds remaining after paying the higher priority claims in full. When the evaluations are completed, the Receiver will file a report with the Court, setting forth the Receiver's recommendations as to amounts, if any, that should be allowed on each of the filed claims evaluated. Notice of the Receiver's recommendations, and the deadline for filing objections to the recommended amounts, will be provided to the claimants at that time. The Receiver will resolve any objections and report back to the Court.

It is unlikely that you will receive any acknowledgement, correspondence, or other communication from the Receiver until the evaluation of the claims is completed, unless the Receiver has questions regarding your filed claim. This is because the Receiver is trying to preserve assets by minimizing the costs of claims processing in order to maximize any potential distribution to the claimants. During the claims evaluation period, the Receiver commences litigation and other activities to identify, locate, collect, and maximize the assets of the receivership estate. It may be several years before distributions of assets, if any, are made in this receivership. It is too early in the receivership process for the Receiver to provide any estimate as to the timing and/or the pro-rata percentage of the distributions, if any, which may be made in this receivership. It is your responsibility to notify the Receiver if you have a change in name or address.

PLEASE NOTE: Under Section 641.315, Florida Statutes, subscribers of a health maintenance organization are not liable to any provider of health care services for any services covered by the health maintenance organization. Additionally, health care providers and their representatives are prohibited from attempting to collect payment from the subscribers for such services. Medical providers currently billing or in any other manner attempting to collect payment from SunStar Health Plan, Inc. subscribers for any medical services are advised to immediately cease such activity. Such medical providers should immediately inform any collection agency they might use of this law and require that it also cease any such collection activity.

IF YOU HAVE A CLAIM, COMPLETE THE REVERSE SIDE. CLAIMS MUST BE POSTMARKED ON OR BEFORE THE DEADLINE FOR FILING CLAIMS. (see above). Late filed claims may receive a smaller payment or even no payment on the claim.

PROVIDER PROOF OF CLAIM FORM

ADDRESS TO MAIL CLAIMS AND OTHER CORRESPONDENCE

Florida Department of Insurance, Receiver of SunStar Health Plan, Inc.
c/o Companion Information Management Resources (AH-200)
P.O. Box 100115
Columbia, South Carolina 29202-3115

TELEPHONE NUMBERS

(800) 882-3054

(850) 922-9115 (fax)

CAREFULLY REVIEW INSTRUCTIONS BEFORE COMPLETING FORM!

A. CLAIM FOR LOSS COVERED BY THE POLICY OR OTHER CLAIM AGAINST THE COMPANY

Claimant's Name:
Address:



Federal Tax ID #/SS #:



SunStar Provider ID #: 591479938

Daytime Telephone: () - -

Receivership ID #: 489-0000810092-00001

RECEIVER'S RECOMMENDATION - (REVIEW SUMMARY REMITTANCE ADVICE & INSTRUCTIONS):

TOTAL AMOUNT OF CLAIM: 478.91 -

Priority of Claim: General Creditor Priority

I AGREE WITH THE RECEIVER'S RECOMMENDATION AS TO THE PRIORITY AND THE TOTAL AMOUNT OF THIS CLAIM AS PRE-PRINTED ABOVE (AND SHOWN ON THE "GRAND NET TOTAL LIABILITY TO CLAIMANT" LINE ON SUMMARY REMITTANCE ADVICE): (check only one) YES NO

Are there any lawsuits pending on this claim? NO YES

(If yes, provide your attorney's name, address & phone number and attach copies of any legal pleadings)

B. IF YOU HAVE CLAIMS NOT INCLUDED IN THE SUMMARY REMITTANCE ADVICE OR HAVE OTHER CORRECTIONS OR CHANGES TO YOUR CLAIM, ATTACH A LIST OF ALL SUCH CLAIMS. A sample of such a list is included in the instructions. For each patient/claim included on your list, you MUST attach copies of the following as appropriate:

- (a) HCFA 1500 Forms
- (b) UB92 Forms
- (c) Eligibility or Coverage Verification
- (d) Other documentation

C. COMPLETE THIS SECTION IF YOU ARE A PROVIDER WITH A SECURED CLAIM

Is the claim a "secured claim"? No Yes (SEE INSTRUCTIONS AS TO DEFINITION OF SECURED CLAIM)

If yes, describe the property or collateral which comprises the "security": _____

If yes, what is the approximate value of the property/collateral which comprises the "security": \$ _____

This "security" claim covers services or supplies for the following period: ____/____/____ to ____/____/____

D. I swear or affirm that I am the claimant referenced in the mailing address on this form and/or am authorized to sign this form on the claimant's behalf. I further swear under penalty of law that all the information contained on this form as well as all attachments are true and correct to the best of my knowledge. Additionally, if I indicated by checking "yes" in the appropriate space above that I agree with the Receiver's recommendation as to the amount and priority of my claim, I understand that the Receiver will present this recommendation to the court and I hereby waive any and all rights to any objection regarding the claim.

Signature of/for Claimant _____

Date Signed _____

Printed name of person signing and position in company _____

Subscribed and sworn to me this ____ day of _____, 20 ____

Personally known to me

Notary Public: _____ Seal

Produced Identification _____
(Type of Identification)

State of: _____ County of: _____

RECEIVED

INSTRUCTIONS FOR COMPLETING PROVIDER PROOF OF CLAIM FORM

GENERAL INFORMATION

1. **THIS IS NOT A BILL.** You (the person or entity listed in the mailing address) have been identified as a person/entity that might be owed money by SunStar Health Plan, Inc., ("SunStar"), an HMO which is in liquidation. **IF YOU HAVE A CLAIM AS A HEALTHCARE PROVIDER TO SUNSTAR, YOU MUST USE THIS FORM.** If you do not have a claim, ignore this form.
2. This form is only to be completed by or on behalf of the person/entity listed in the mailing address. Please do not use this form for any other person/entity as it contains a pre-assigned control number that is not transferable. Similarly, do not use a claim form which has been provided to a SunStar member for his/her use. **Provider claims MUST be submitted on Provider Proof of Claim forms.** Please contact the Receiver's office if additional claim forms are needed.
3. **Please mark any address changes on the mailing address portion of this form which is found on the first and second pages.**
4. If you choose to fax your completed Proof of Claim form and supporting documents to the Receiver, you must still submit the original signed Proof of Claim form to the Receiver at the address provided on the form.
5. The Receiver has mailed a Provider Proof of Claim form to the BILLING ADDRESS for each healthcare provider on file with SunStar as of the date of liquidation and to those who have since requested a form. There may be circumstances where Proof of Claim forms have been sent to both a provider group (e.g.: Radiology and Associates) and some but not all of the doctors associated with that group. Please submit a form only for the person or entity that is owed money under the terms of any applicable contract with SunStar.
6. **THE ENCLOSED SUMMARY REMITTANCE ADVICE SHOWS THE RECEIVER'S CURRENT RECORD AND EVALUATION OF CLAIMS SUBMITTED BY YOU, THE PROVIDER, TO SUNSTAR HEALTH PLAN, INC. PLEASE REVIEW THE SUMMARY CAREFULLY BEFORE COMPLETING THIS FORM.**
7. Below please find additional instructions regarding other sections of the Proof of Claim form.

SECTION A

1. **Claimant's Name:** The "Claimant" is the person or entity that is owed money. The "Claimant" name should be the name printed in the mailing address. If not, please contact the Receiver's office for further assistance.
2. **Receivership ID number:** This identification number appears on the UPPER LEFT CORNER ABOVE THE MAILING ADDRESS AND IS PREPRINTED ON ALL OTHER PAGES. It is used to identify the claimant. **NOTE: THE RECEIVERSHIP IDENTIFICATION NUMBER SHOULD BE USED ON ALL CORRESPONDENCE WITH THE RECEIVER.**
3. **SunStar Provider ID Number:** This is the identification number assigned to the healthcare provider by SunStar. The relevant number is found on the upper right corner above the mailing address and is pre-printed on the second page.
4. **Federal Tax ID #:** This may also be a Social Security number if the claimant is an individual.
5. **Total Amount of Claim:** This is the total amount of your claim in the receivership. The Receiver has processed and evaluated all claims which were filed with SunStar as of this mailing. The results of this processing are set out in the enclosed SUMMARY REMITTANCE ADVICE. It is the Receiver's hope that this will assist you in accurately reviewing and filing any claim you may have in this receivership. **YOU SHOULD CAREFULLY READ THE ENCLOSED SUMMARY REMITTANCE ADVICE AND OTHER REMITTANCE INFORMATION SENT BY THE RECEIVER.** The amount shown on the "Grand Net Total Liability To Claimant" line on the Summary Remittance Advice is the amount which the Receiver believes is owed to you by SunStar based on the Receiver's review of SunStar's records. The Receiver has pre-printed this amount on the "Total Amount of Claim" line of this form. **IF YOU AGREE WITH THE AMOUNT WHICH IS PRE-PRINTED ON THE "TOTAL AMOUNT OF CLAIM" LINE, CHECK "YES" WHERE INDICATED ON THE FORM AND SKIP TO SECTION "C".** If you believe that a different amount is owed to you: (a) line through the pre-printed amount, (b) write in the total amount you believe is owed on the line which is provided, (c) check "NO" where indicated, then (d) follow the instructions for Section "B" regarding your claim.
6. **Priority** A detailed explanation of the receivership claims process, including how claims are prioritized and paid, is found on the first page of the claim form. **TIMELY FILED CLAIMS OF HEALTHCARE PROVIDERS ARE AUTOMATICALLY PRIORITIZED AS GENERAL CREDITOR CLAIMS.** (If a claim form is not received until after the claims filing deadline, it is prioritized as a "late filed claim," a lower priority which generally does not share in any distribution due to lack of assets.) Any distribution to the General Creditor level will be made on a pro-rata basis. IF a distribution is made, you may not receive the full amount recommended or allowed on your claim. Depending on the assets available for distribution, you and other claimants in your classification may only receive a percentage of the amount allowed on your claim. **NOTE: IF a distribution is made, the payee(s) names(s) on the distribution check will be the same as the name(s) appearing on the mailing address on the first page of this form. If the information on this form is incorrect, or becomes incorrect in the future, it is your responsibility to notify the Receiver and document any changes.**
7. **"I agree with the Receiver's Recommendation..."**
 - (a) **"YES"** - If you agree with the Receiver that the pre-printed "Total Amount of Claim" is the amount which SunStar owes you, indicate your agreement with the amount by checking "YES" on this line as indicated. **NOTE: IF YOU CHECK "YES," YOU ARE INDICATING THAT YOU AGREE WITH THE RECEIVER REGARDING**

RECEIVERSHIP ID #: 489-0000810092-00001

THE EVALUATION OF YOUR CLAIM, BOTH AS TO THE PRIORITY OF THE CLAIM AND THE AMOUNT DUE TO YOU. IF YOU CHECK "YES," THE RECEIVER WILL PRESENT THIS RECOMMENDATION TO THE COURT. SINCE YOU THEREBY AGREE WITH RECEIVER'S RECOMMENDATION, YOU WILL WAIVE ANY AND ALL RIGHTS TO OBJECTIONS REGARDING YOUR CLAIM. This means that your claim will be allowed as a General Creditor claim for the amount listed as the "Total Amount of Claim" on the Proof of Claim form. Your agreement here will help expedite the processing of claims in this receivership.

(b) "NO" - If you do NOT agree with the pre-printed "Total Amount of Claim," check "NO" on this line and follow the directions provided in Section "B." If you check "NO" here, you will be contacted after your claim has been re-evaluated and provided the opportunity to object to the results of the Receiver's re-evaluation of your claim. Please remember to line through the pre-printed "Total Amount of Claim" and write the amount which you believe you are owed in the space provided.

8. Lawsuits: You are again reminded that Section 641.315, Florida Statutes, prohibits providers and/or their representatives from attempting to collect payment from the subscribers of a health maintenance organization for any services which would be covered by the health maintenance organization. If there are lawsuits against the former SunStar members for any such services, you should immediately cease such collection activity.

SECTION B

1. ONLY COMPLETE THIS SECTION IF YOU BELIEVE YOU HAVE CLAIMS WHICH WERE NOT INCLUDED IN THE SUMMARY REMITTANCE ADVICE.
2. If the Summary Remittance Advice is NOT correct, return a copy of the (a) Summary Remittance Advice along with (b) documentation for any corrections, changes, and/or additional claims, and (c) the completed Proof of Claim form. On the space provided next to the "Total Amount of Claim" line of Section A, enter the amount YOU calculate as being owed, derived from the Summary Remittance Advice form and the corrections, changes, and/or additional claims.
3. If your corrections, changes, and/or additional claims involve more than one subscriber or claim, please attach a list. (If the Summary Remittance Advice is correct, no listing is required.) The list should itemize how you calculated the total amount of your claim. For your convenience, you may use the form below. If more lines are needed, please attach additional sheet(s). Also, remember that for each patient you include on the list, you MUST attach copies of the following as appropriate: HCFA 1500 Forms, UB92 Forms, Eligibility or Coverage Verification and/or other relevant documentation.

PATIENT	DATE OF SERVICE	SUBSCRIBER/ MEMBER	MEMBER'S SS# OR FEDERAL ID#	OTHER INFORMATION	AMOUNT OF CLAIM
TOTAL (write this amount on the TOTAL AMOUNT OF CLAIM line, Section A, of the Provider Proof of Claim form):					

SECTION C

1. ONLY complete this section if you received a deposit (or other collateral) from SunStar which you believe should be used to pay your claim. In some circumstances, this may be considered a "secured" claim under applicable receivership provisions. If you have questions regarding this Section, call the Receiver's office for assistance.

SECTION D

ALL CLAIMANTS MUST COMPLETE THIS SECTION IN FRONT OF A NOTARY PUBLIC.

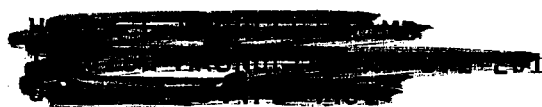
1. Signature of/for Claimant: This MUST be done in front of a notary public. If the claimant is an individual, the person signing must be the individual claimant or authorized representative. If the claimant is an entity other than an individual, the person signing must be a company officer or authorized representative and must write in his/her position in the company.
2. IF you indicated in Section A that you agree with the Receiver's recommendation regarding the amount and priority of your claim, the Receiver will present this recommendation to the Court. You therefore hereby waive any and all rights to object regarding the priority and amount allowed on your claim. Your agreement regarding this matter should help to expedite the claims evaluation process.



RECEIVERSHIP ID #: 489-0000810092-00001

RECEIVER ID: 489-0000810092-00001
HPS PERIOD - 4/97 TO 6/30/99

**SUNSTAR
IN RECEIVERSHIP**



PATIENT INFORMATION

ACCOUNT NUMBER	IDENTIFICATION NUMBER	NAME	PHYSICIAN NUMBER OR EIN	DATE OF SERVICE			PROCEDURE			DAYS/ UNITS	CHARGE SUBMITTED	AMOUNT ALLOWED	PATIENT LIABILITY		LIABILITY	
				M	D	Y	CODE	M	M				M	DEDUCT.		
24100	264706186	JOHNSON MARGAR	591479938	04	07	98						CLAIM	TOTAL	25.55	CL	8154SG20400
26100	264706186	JOHNSON MARGAR	591479938	08	26	98						CLAIM	TOTAL	27.80	CL	91251080000
23421	266561729	SENSANBA LLOYD	591479938	06	10	98						CLAIM	TOTAL	58.96	CL	SB173000100
23420	266561729	SENSANBA NORMA	591479938	02	19	99						CLAIM	TOTAL	32.67	CL	9084S180200
2981	213420330	WHITBY KATHRY	591479938	07	15	98						CLAIM	TOTAL	60.67	CL	SB204000100
2981	213420330	WHITBY KATHRY	591479938	08	20	98						CLAIM	TOTAL	160.12	CL	SB245000100
TOTAL													345.37			

5 [REDACTED]

RECEIVER ID: 489-0000810092-00001
HPS PERIOD - 4/97 TO 6/30/99

**SUNSTAR
IN RECEIVERSHIP**



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PATIENT INFORMATION



ACCOUNT NUMBER	IDENTIFICATION NUMBER	NAME	PHYSICIAN NUMBER OR EIN	DATE OF SERVICE			PROCEDURE			DAYS/ UNITS	CHARGE SUBMITTED	AMOUNT ALLOWED	PATIENT LIABILITY		LIABILITY
				M O	D A	Y R	CODE	M O D	M O D				M O D	DEDUCT.	

RECEIVERSHIP OF SUNSTAR HEALTH PLAN, INC.

SUMMARY REMITTANCE ADVICE

RECEIVERSHIP ID #:

489-0000810092-00001

I. HPS & SUNSTAR PERIODS

A.	HPS PERIOD - 4/97 to 6/30/99 See claims detail, separate page		
	TOTAL LIABILITY/PAYMENTS MADE	\$	<u>345.37</u>
B.	SUNSTAR PERIOD - run-off to 6/30/99 See claims detail, separate page		
	TOTAL CLAIMS LIABILITY	\$	<u>0.00</u>
	TOTAL PAYMENTS MADE	\$	<u>478.91</u>

TOTAL SUNSTAR & HPS PERIOD LIABILITY	\$	<u>345.37</u>
-TOTAL HPS PERIOD PAYMENTS MADE	\$	<u>345.37</u>
<u>-TOTAL SUNSTAR PERIOD PAYMENTS MADE</u>	\$	<u>478.91</u>
NET TOTAL LIABILITY FOR HPS & SUNSTAR PERIODS	\$	<u>478.91-</u>

II. cimr PERIOD - 7/1/99 to 2/1/00

See claims detail, separate page		
TOTAL OUTSTANDING CLAIMS LIABILITY	\$	<u>0.00</u>

III. TOTAL LIABILITY TO CLAIMANT:

NET TOTAL LIABILITY FOR HPS & SUNSTAR PERIODS	\$	<u>478.91-</u>
+ TOTAL cimr PERIOD O/S CLAIMS LIABILITY	\$	<u>0.00</u>
GRAND NET TOTAL LIABILITY TO CLAIMANT	\$	<u>478.91-</u>

EXPLANATION:

BACKGROUND: SunStar Health Plan, Inc., ("SunStar") began operations as an HMO in 1997. From 1997 through June 30, 1999, SunStar contracted with Health Plan Services, Inc., ("HPS"), to process and evaluate its claims (the "HPS Period"). SunStar's contract with HPS terminated effective June 30, 1999. However, since most provider contracts gave the healthcare providers 60 days or more to file claims, "run off" claims were anticipated. SunStar attempted to process and evaluate these "run off" claims in-house (the "SunStar Period"). For claims with dates of service on and after July 1, 1999, SunStar contracted with Companion Information Management Resources ("cimr") to process the claims. cimr continued its duties as SunStar's third party administrator until liquidation, February 1, 2000 (the "cimr Period").

EVALUATION: The Receiver has processed and evaluated all claims (for dates of service prior to February 1, 2000) which were filed with SunStar as of the date of this mailing. The Receiver contracted with cimr to process and evaluate the claims which are filed in the receivership. The results of this processing are set out above and on the enclosed Remittance Advices for the HPS, SunStar, and cimr periods. PLEASE CAREFULLY REVIEW THE ENCLOSED REMITTANCE ADVICES. In order to best reconcile SunStar's records to arrive at the net amount owed claimants, the Receiver used the following method:

- (a) HPS Period - The Receiver used SunStar's bank statements to confirm payment on claims. The Remittance Advice for the HPS Period only shows the claims which were PAID to you as confirmed on the bank statements. This amount also reflects SunStar's claims liability to you for this period.

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RECEIVERSHIP OF SUNSTAR HEALTH PLAN, INC.

- (b) SunStar Period - It was impossible to determine from SunStar's in-house records which claims had been evaluated and/or paid. Thus, ALL claims filed during the SunStar Period had to be re-evaluated. The Remittance Advice for the SunStar Period provides detail on this re-evaluation and shows the total claims you filed during this period. The Summary Remittance Advice (above) shows the total amount of claims you filed during this period and the total payments which SunStar made to you according to SunStar's bank records. The amounts paid to you during the HPS and SunStar Periods are reconciled with the claims you filed and the NET total amount due you for those periods reflected on the "Net Total Liability For HPS & SunStar Periods" line above.
- (c) cimr Period - Only the outstanding, unpaid claims are shown on the Remittance Advice for the cimr Period. The total amount due you for claims filed during the cimr Period is reflected on the "Total Outstanding Claims Liability" line under the "cimr Period" above.

Note regarding evaluation: In order to more cost effectively and expeditiously process the claims in the receivership, all previously unprocessed claims, regardless of the date of service, have been evaluated using the terms of the most recent contract between the provider and SunStar as reflected in SunStar's data files. Pursuant to Court order, for claims where there is no existing contract, the covered claims have been allowed at (a) Medicare area prevailing rates or (b) 70% of billed charges.

TOTAL NET LIABILITY TO CLAIMANT: The Receiver reconciled the amounts owed to you during all above described claim periods to arrive at the NET total amount due you according to SunStar's records. **THIS AMOUNT IS SHOWN ON THE "GRAND NET TOTAL LIABILITY TO CLAIMANT" LINE ON THIS SUMMARY REMITTANCE ADVICE** and is pre-printed as the "Total Amount of Claim" on your Provider Proof of Claim form. Please follow the Instructions for the Provider Proof of Claim form to complete your claim in the receivership. **NOTE: YOU MUST FILE YOUR CLAIM ON THE PROVIDER PROOF OF CLAIM FORM IN ORDER TO BE ELIGIBLE FOR ANY DISTRIBUTION FROM THIS ESTATE.**

If the amount shown on the "Grand Net Total Liability To Claimant" line is a negative number, that means that you potentially received more payments from SunStar than the allowed amount of your claims. You may owe that amount to the receivership estate. Do not send any money at this time. The Receiver will contact you further regarding this matter. Also, the Receiver herein reserves the right to collect from you for any duplicate payments which may be discovered.

QUESTIONS: If you have additional questions regarding the above Remittance Advice, please contact the Receiver at the address or phone numbers provided below. Remember to use your Receivership ID # in any communication with the Receiver.

Florida Department of Insurance, Receiver of SunStar Health Plan, Inc.
c/o Companion Information Management Resources (AH-200)
P.O. Box 100115
Columbia, South Carolina 29202-3115

Phone: (800) 882-3054
Fax: (850) 922-9115

DUPLICATE COPY

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF REHABILITATION AND LIQUIDATION
 SUNSTAR HEALTHPLAN
 FIRST INTERIM FILED CLAIMS REPORT
 FILED CLAIMS - CLAIMANT AGREED WITH REMITTANCE AMOUNT (PART A)

SUMMARY TOTALS

AMOUNT CLAIMED	\$7,183,548.11
AMOUNT RECOMMENDED TO CLAIMANT	\$6,861,227.09
TOTAL NUMBER	1,667

COUNT OF CLASS 1 CLAIMS :	0	COUNT OF CLASS 6 CLAIMS :	1,667
UNT CLAIMED FOR CLASS 1 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 6 CLAIMS :	\$7,183,548.11
AMOUNT RECMD TO CLAIMANT FOR CLASS 1 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 6 CLAIMS :	\$6,861,227.09
COUNT OF CLASS 2 CLAIMS :	0	COUNT OF CLASS 7 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 2 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 7 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 2 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 7 CLAIMS :	\$0.00
COUNT OF CLASS 3 CLAIMS :	0	COUNT OF CLASS 8 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 3 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 8 CLAIMS :	\$0.00
AMOUNT DUE CLAIMANT FOR CLASS 3 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 8 CLAIMS :	\$0.00
COUNT OF CLASS 4 CLAIMS :	0	COUNT OF CLASS 9 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 4 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 9 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 4 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 9 CLAIMS :	\$0.00
COUNT OF CLASS 5 CLAIMS :	0	COUNT OF CLASS 10 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 5 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 10 CLAIMS :	\$0.00
/ INT RECMD TO CLAIMANT FOR CLASS 5 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 10 CLAIMS :	\$0.00

10

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF REHABILITATION AND LIQUIDATION
 SUNSTAR HEALTHPLAN
 FIRST INTERIM FILED CLAIMS REPORT
 FILED CLAIMS - AGENT / AGENCY (PART B)

SUMMARY TOTALS

AMOUNT CLAIMED	\$748,885.63
AMOUNT RECOMMENDED TO CLAIMANT	\$251,132.32
TOTAL NUMBER	298

COUNT OF CLASS 1 CLAIMS :	0	COUNT OF CLASS 6 CLAIMS :	296
AMOUNT CLAIMED FOR CLASS 1 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 6 CLAIMS :	\$747,212.63
AMOUNT RECMD TO CLAIMANT FOR CLASS 1 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 6 CLAIMS :	\$251,132.32
COUNT OF CLASS 2 CLAIMS :	0	COUNT OF CLASS 7 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 2 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 7 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 2 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 7 CLAIMS :	\$0.00
COUNT OF CLASS 3 CLAIMS :	0	COUNT OF CLASS 8 CLAIMS :	2
AMOUNT CLAIMED FOR CLASS 3 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 8 CLAIMS :	\$1,673.00
AMOUNT DUE CLAIMANT FOR CLASS 3 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 8 CLAIMS :	\$0.00
COUNT OF CLASS 4 CLAIMS :	0	COUNT OF CLASS 9 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 4 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 9 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 4 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 9 CLAIMS :	\$0.00
COUNT OF CLASS 5 CLAIMS :	0	COUNT OF CLASS 10 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 5 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 10 CLAIMS :	\$0.00
JNT RECMD TO CLAIMANT FOR CLASS 5 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 10 CLAIMS :	\$0.00

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF REHABILITATION AND LIQUIDATION
 SUNSTAR HEALTHPLAN
 FIRST INTERIM FILED CLAIMS REPORT
 FILED CLAIMS - SUBSCRIBER / GROUP (PART C)

SUMMARY TOTALS

AMOUNT CLAIMED	\$1,693,463.67
AMOUNT RECOMMENDED TO CLAIMANT	\$139,767.77
TOTAL NUMBER	1,841

COUNT OF CLASS 1 CLAIMS :	0	COUNT OF CLASS 6 CLAIMS :	0
A NT CLAIMED FOR CLASS 1 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 6 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 1 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 6 CLAIMS :	\$0.00

COUNT OF CLASS 2 CLAIMS :	1,269	COUNT OF CLASS 7 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 2 CLAIMS :	\$1,322,701.64	AMOUNT CLAIMED FOR CLASS 7 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 2 CLAIMS :	\$82,788.06	AMOUNT RECMD TO CLAIMANT FOR CLASS 7 CLAIMS :	\$0.00

COUNT OF CLASS 3 CLAIMS :	511	COUNT OF CLASS 8 CLAIMS :	61
AMOUNT CLAIMED FOR CLASS 3 CLAIMS :	\$314,848.79	AMOUNT CLAIMED FOR CLASS 8 CLAIMS :	\$55,913.24
AMOUNT DUE CLAIMANT FOR CLASS 3 CLAIMS :	\$56,979.71	AMOUNT RECMD TO CLAIMANT FOR CLASS 8 CLAIMS :	\$0.00

COUNT OF CLASS 4 CLAIMS :	0	COUNT OF CLASS 9 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 4 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 9 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 4 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 9 CLAIMS :	\$0.00

COUNT OF CLASS 5 CLAIMS :	0	COUNT OF CLASS 10 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 5 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 10 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 5 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 10 CLAIMS :	\$0.00

FLORIDA DEPARTMENT OF FINANCIAL SERVICES - DIVISION OF REHABILITATION AND LIQUIDATION
 SUNSTAR HEALTHPLAN
 FIRST INTERIM FILED CLAIMS REPORT
 FILED CLAIMS - PROVIDER (PART D)

SUMMARY TOTALS

AMOUNT CLAIMED	\$41,678,499.28
AMOUNT RECOMMENDED TO CLAIMANT	\$21,785,187.48
TOTAL NUMBER	2,581

COUNT OF CLASS 1 CLAIMS :	0	COUNT OF CLASS 6 CLAIMS :	2,385
AMOUNT CLAIMED FOR CLASS 1 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 6 CLAIMS :	\$37,549,105.14
AMOUNT RECMD TO CLAIMANT FOR CLASS 1 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 6 CLAIMS :	\$21,785,187.48
COUNT OF CLASS 2 CLAIMS :	0	COUNT OF CLASS 7 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 2 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 7 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 2 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 7 CLAIMS :	\$0.00
COUNT OF CLASS 3 CLAIMS :	0	COUNT OF CLASS 8 CLAIMS :	196
AMOUNT CLAIMED FOR CLASS 3 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 8 CLAIMS :	\$4,129,394.14
AMOUNT DUE CLAIMANT FOR CLASS 3 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 8 CLAIMS :	\$0.00
COUNT OF CLASS 4 CLAIMS :	0	COUNT OF CLASS 9 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 4 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 9 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 4 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 9 CLAIMS :	\$0.00
COUNT OF CLASS 5 CLAIMS :	0	COUNT OF CLASS 10 CLAIMS :	0
AMOUNT CLAIMED FOR CLASS 5 CLAIMS :	\$0.00	AMOUNT CLAIMED FOR CLASS 10 CLAIMS :	\$0.00
AMOUNT RECMD TO CLAIMANT FOR CLASS 5 CLAIMS :	\$0.00	AMOUNT RECMD TO CLAIMANT FOR CLASS 10 CLAIMS :	\$0.00

Receiver ship of SunStar Health Plan, Inc.
Claim Evaluation Summary (Agent/Agency)

Receivership ID: 489-0000900102-00001

ID Number: 

Name: 

Address: 

City/State/Zip: 

Claim

Amount Claimed: \$7,500.00

Amount Recommended : \$6,714.05

Priority of Claim: CLASS 6 - GENERAL CREDITOR CLAIMS

Objection Filing Deadline: 01/01/2004

SunStar Health Plan, Inc. ("SunStar") was declared financially insolvent and is in liquidation proceedings before the Circuit Court, Leon County, Tallahassee, Florida. The Court appointed the Florida Department of Financial Services as the Receiver of SunStar. The information on this Claim Evaluation Summary reflects the Receiver's evaluation of your claim, including the "Amount Recommended" and the "Class" or "Priority" of your claim.

Please refer to the Notice to Claimants enclosed with your Claim Evaluation Summary for more information regarding this document and for instructions on what to do if you do not agree with this information.

Please note that all objections must be postmarked before the Objection Filing Deadline stated above.

COMPOSITE
EXHIBIT "H"

RE: SUNSTAR HEALTH PLAN, INC.

Civil Action: 99-6705
2nd Judicial Circuit Court
Leon County, Florida

OBJECTION FILING DEADLINE:
01/01/2004

THIS IS NOT A BILL. SunStar Health Plan, Inc. ("SunStar") was declared financially insolvent and is in liquidation proceedings before the Circuit Court, Leon County, Tallahassee, Florida. The Court appointed the Florida Department of Insurance as the Receiver of SunStar. The purpose of this Notice to Claimants is to inform you of the Receiver's final recommendations to the Circuit Court concerning the classifications and amounts on a claim filed by you in the receivership estate of SunStar. To obtain a copy of the court order approving the Receiver's recommendation, please go to the Receiver's website at www.floridainsurancereceiver.org or send a written request for the order to the address below. The information on the attached Claim Evaluation Summary reflects the Receiver's evaluation of your claim, including the "Amount Recommended" and the "Class" or "Priority" of your claim.

The "Class" or "Priority" of your claim can affect the amount of money you may receive from the SunStar estate. Please be advised that the assets in the Receivership estate of SunStar are not sufficient to fund a distribution payment to all claimants. Florida Statute 631.271, "Priority of Claims", defines the classification of claims. (See F.S. 631.271 on reverse side of this form.) Every claim in each class, beginning with Class 1, must be paid in full before the members of the next class may receive any payment. Below is a brief description of the class of claims being reported to the Court:

- Class 1 Cost & expenses of the Receiver and state guaranty funds
- Class 2 Loss claims covered by the policy (claims by subscribers for reimbursement of expenses which should have been paid by the HMO)
- Class 3 Refund of unearned premium on non-assessable policies
- Class 4 Claims of the Federal Government
- Class 5 Claims of employees
- Class 6 Claims of general creditors (claims by providers)
- Class 7 Claims of any state or local government
- Class 8 Claims filed late
- Class 9 Surplus or contribution notes & refunds on assessable policies
- Class 10 Claims of shareholders or other owners

PLEASE review the attached Claim Evaluation Summary, including the amount on the line reading "Amount Recommended" and the "Priority of Claim" section. If you agree with the amount recommended and the class/priority, no further action on your part is necessary.

If, on the other hand, you object to the recommended amount or to the assigned class of your claim, YOU MUST FILE AN OBJECTION. If your class/priority has been identified as Class 7 through Class 10, you may object only to the Receiver's classification of your claim. If your claim was late filed (Class 8), you may object only to the Receiver's classification of your claim. All objections must be postmarked before the Objection Filing Deadline stated above.

OBJECTION PROCEDURE:

If you are filing an objection, please follow the procedure below:

1. State in detail all legal and factual reasons for your objection. At the top of your statement, include the following information: "Civil Action Number 99-6705", your identification number, correct address and telephone number.
2. Attach a copy of this notice to your objection.
3. Attach documentation to support your objection.
4. Mail the original objection package to the Clerk of Court, a copy to the Receiver at the address below, and keep a copy for yourself.
5. Once your objection is filed, the Receiver will evaluate the materials you submitted and you will be contacted regarding your objection. If your objection cannot be resolved, a hearing will be scheduled before the Circuit Court, Leon County, Florida.

YOUR OBJECTION MUST BE FILED WITH **BOTH** THE RECEIVER AND THE CLERK OF COURT, SECOND JUDICIAL CIRCUIT, LEON COUNTY COURT HOUSE, 301 S. MONROE STREET, TALLAHASSEE, FLORIDA 32301. YOUR OBJECTION MUST BE POSTMARKED BY THE DEADLINE GIVEN ABOVE. THE RECEIVER SUGGESTS THAT YOU SEND YOUR OBJECTION BY CERTIFIED MAIL, RETURN RECEIPT REQUESTED.

NOTE: Any distribution will be made on a pro-rata basis. If a distribution is made, you may not receive the full amount recommended for your claim. Depending on the assets available for distribution, you and other claimants in your classification may only receive a percentage of the amount recommended on your claim (i.e. 25% equals 25 cents on the dollar).

If a distribution is made, the payee(s) name(s) on the claim check will be the same as the name(s) appearing on the Claim Evaluation Summary. If the information on this form is incorrect, or becomes incorrect in the future, it is your responsibility to notify the Receiver and document any changes.

FLORIDA DEPARTMENT OF FINANCIAL SERVICES, RECEIVER

SUNSTAR HEALTH PLAN, INC.

C/O Companion Information Management Resources

I-20 @ Alpine Road - Mail Code (AF-170)

Columbia, South Carolina 29219

www.floridainsurancereceiver.org

Telephone: (803) 264-8100, Facsimile (803) 264-7356

**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
RECEIVER FOR
SUNSTAR HEALTH PLAN, INC.**

FLORIDA STATUTE 631.271 Priority of claims

631.271 Priority of claims. —

- (1) The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this subsection. Every claim in each class shall be paid in full or adequate funds shall be retained for such payment before the members of the next class may receive any payment. No subclasses may be established within any class. The order of distribution of claims shall be:
- (a) Class 1. —
 - 1. All of the receiver's costs and expenses of administration.
 - 2. All of the expenses of a guaranty association or foreign guaranty association in handling claims.
 - (b) Class 2. — All claims under policies for losses incurred, including third-party claims, all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which claims are not under policies, and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, may not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to her or his employee may be treated as a gratuity.
 - (c) Class 3. — Claims under nonassessable policies for unearned premiums or premium refunds.
 - (d) Class 4. — Claims of the Federal Government.
 - (e) Class 5. — Debts due to employees for services performed, to the extent that the debts do not exceed \$2,000 for each employee and represent payment for services performed within 6 months before the filing of the petition for liquidation. Officers and directors are not entitled to the benefit of this priority. This priority is in lieu of any other similar priority that is authorized by law as to wages or compensation of employees.
 - (f) Class 6. — Claims of general creditors.
 - (g) Class 7. — Claims of any state or local government. Claims, including those of any state or local government for a penalty or forfeiture, shall be allowed in this class, but only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under paragraph (j).
 - (h) Class 8. — Claims filed after the time specified in ss. 631.181(3), except when ordered otherwise by the court to prevent manifest injustice, or any claims other than claims under paragraph (i) or under paragraph (j).
 - (i) Class 9. — Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.
 - (j) Class 10. — The claims of shareholders or other owners.
- (2) In a liquidation proceeding involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

FLORIDA DEPARTMENT OF FINANCIAL SERVICES, RECEIVER
SUNSTAR HEALTH PLAN, INC.
C/O Companion Information Management Resources
I-20 @ Alpine Road - Mail Code (AF-170)
Columbia, South Carolina 29219
www.floridainsurancereceiver.org
Telephone: (803) 264-8100, Facsimile: (803) 264-7356

**Receivership of SunStar Health Plan, Inc.
Claim Evaluation Summary (Provider)**

Receivership ID: 489-0000801440-00001
ID Number: [REDACTED]
Name: [REDACTED]
Address: [REDACTED]
City/State/Zip: [REDACTED]

Net Total Liability from Proof-of-Claim¹: \$120.00
Amount Claimed: \$120.00
Amount Recommended²: \$668.74

Priority of Claim: CLASS 6 - GENERAL CREDITOR CLAIMS

Objection Filing Deadline: 01/01/2004

SunStar Health Plan, Inc. ("SunStar") was declared financially insolvent and is in liquidation proceedings before the Circuit Court, Leon County, Tallahassee, Florida. The Court appointed the Florida Department of Financial Services as the Receiver of SunStar. The information on this Claim Evaluation Summary reflects the Receiver's evaluation of your claim, including the "Amount Recommended" and the "Class" or "Priority" of your claim. Please refer to the Notice To Claimants enclosed with your Claim Evaluation Summary for more information regarding this document and for instructions on what to do if you do not agree with this information. **Please note that all objections must be postmarked before the Objection Filing Deadline stated above.** Also, please refer to the Summary Remittance Advice (provided to you with your proof of Claim form) for more information on how your claim was evaluated.

¹ "Net Total Liability from Proof of Claim" is the amount the Receiver determined was due you after a reconciliation of SunStar's records. This amount was shown on the "Grand Net Total Liability to Claimant" line on your Summary Remittance Advice and was pre-printed as the "Total Amount of Claim" on the Provider Proof of Claim form you used to file your claim.

² Details regarding the total liability were provided initially in the Remittance Advice which was mailed to you with a Proof of Claim form for you to complete. The "Amount Recommended" which is printed above includes deductions for voided checks, duplicate payments, and other conditions which would alter the amount due on your claim.

THIS IS NOT A BILL NOTICE TO CLAIMANTS THIS IS NOT A BILL

RE: SUNSTAR HEALTH PLAN, INC.

Civil Action: 99-6705
2nd Judicial Circuit Court
Leon County, Florida

OBJECTION FILING DEADLINE:

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 - 2. All of the expenses of a guaranty association or foreign guaranty association in handling claims.
 - (b) Class 2. — All claims under policies for losses incurred, including third-party claims, all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which claims are not under policies, and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, may not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to her or his employee may be treated as a gratuity.
 - (c) Class 3. — Claims under nonassessable policies for unearned premiums or premium refunds.
 - (d) Class 4. — Claims of the Federal Government.
 - (e) Class 5. — Debts due to employees for services performed, to the extent that the debts do not exceed \$2,000 for each employee and represent payment for services performed within 6 months before the filing of the petition for liquidation. Officers and directors are not entitled to the benefit of this priority. This priority is in lieu of any other similar priority that is authorized by law as to wages or compensation of employees.
 - (f) Class 6. — Claims of general creditors.
 - (g) Class 7. — Claims of any state or local government. Claims, including those of any state or local government for a penalty or forfeiture, shall be allowed in this class, but only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under paragraph (j).
 - (h) Class 8. — Claims filed after the time specified in ss. 631.181(3), except when ordered otherwise by the court to prevent manifest injustice, or any claims other than claims under paragraph (i) or under paragraph (j).
 - (i) Class 9. — Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.
 - (j) Class 10. — The claims of shareholders or other owners.
- (2) In a liquidation proceeding involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

FLORIDA DEPARTMENT OF FINANCIAL SERVICES, RECEIVER
SUNSTAR HEALTH PLAN, INC.
C/O Companion Information Management Resources
1-20 @ Alpine Road - Mail Code (AF-170)
Columbia, South Carolina 29219
www.floridainsurancereceiver.org
Telephone: (803) 264-8100, Facsimile: (803) 264-7356

**SUNSTAR
IN RECEIVERSHIP**



PATIENT INFORMATION

ACCOUNT NUMBER	IDENTIFICATION NUMBER	NAME	PHYSICIAN NUMBER OR EIN	DATE OF SERVICE			PROCEDURE			DAYS/ UNITS	CHARGE SUBMITTED	AMOUNT ALLOWED	PATIENT LIABILITY		LIABILITY	
				M	D	Y	CODE	M	O				D	DEDUCT.		OTHER
	K263884211	SILVERSM CHRIST	029385680	010700	0806	29	00			1	150.00	120.00	.00	50.00	100.00	367
			029385680	012800	0806	29	00			1	150.00	120.00	.00	50.00	100.00	367
								CLAIM TOTAL			300.00	240.00	.00	100.00	200.00	CL K033251480000
	K263884211	SILVERSM GAIL	029385680	110299	0806	29	00			1	150.00	120.00	.00	30.00	120.00	367
			029385680	110999	0806	29	00			1	150.00	120.00	.00	30.00	120.00	367
			029385680	111699	0806	29	00			1	150.00	120.00	.00	41.26	108.74	389
			029385680	112399	0806	29	00			1	150.00	120.00	.00	150.00	.00	389
			029385680	113099	0806	29	00			1	150.00	120.00	.00	150.00	.00	389
											CLAIM TOTAL		750.00	600.00	.00	401.26
	K263884211	SILVERSM GAIL	029385680	010400	0806	29	00			1	150.00	50.00	.00	120.00	30.00	
			029385680	011100	0806	29	00			1	150.00	50.00	.00	120.00	30.00	
			029385680	011800	0806	29	00			1	150.00	50.00	.00	120.00	30.00	
			029385680	012500	0806	29	00			1	150.00	50.00	.00	120.00	30.00	
											CLAIM TOTAL		600.00	200.00	.00	480.00

367 AMOUNT EXCEEDS MAXIMUM ALLOWANCE

389 MAXIMUM BENEFITS HAVE BEEN PAID FOR THIS TYPE SERVICE

**SUNSTAR
IN RECEIVERSHIP**



PATIENT INFORMATION

ACCOUNT NUMBER	IDENTIFICATION NUMBER	NAME	PHYSICIAN NUMBER OR EIN	DATE OF SERVICE			PROCEDURE			DAYS/ UNITS	CHARGE SUBMITTED	AMOUNT ALLOWED	PATIENT LIABILITY		LIABILITY
				M O	D A	Y R	CODE	M O D	M O D				M O D	DEDUCT.	
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**Receivership of SunStar Health Plan, Inc.
Claim Evaluation Summary (Subscriber/Group)**

Receivership ID: 489-0000000440-00001

ID Number: [REDACTED]

Name: [REDACTED]

Address: [REDACTED]

City/State/Zip: [REDACTED]

A. Loss Claim

Amount Claimed: \$224.93

Amount Recommended: \$0.00

Priority of Claim: CLASS 2 - LOSS CLAIMS BY SUBSCRIBERS FOR REIMBURSEMENT OF EXPENSES PAID WHICH SHOULD HAVE BEEN PAID BY THE HMO

Objection Filing Deadline: 01/01/2004

B. Unearned Premium

Amount Claimed: N/A

Amount Recommended: N/A

Priority of Claim

Objection Filing Deadline:

SunStar Health Plan, Inc. ("SunStar") was declared financially insolvent and is in liquidation proceedings before the Circuit Court, Leon County, Tallahassee, Florida. The Court appointed the Florida Department of Financial Services as the Receiver of SunStar. The information on this Claim Evaluation Summary reflects the Receiver's evaluation of your claim, including the "Amount Recommended" and the "Class" or "Priority" of your claim. Please refer to the Notice To Claimants enclosed with your Claim Evaluation Summary for more information regarding this document and for instructions on what to do if you do not agree with this information. **Please note that all objections must be postmarked before the Objection Filing Deadline stated above.**

THIS IS NOT A BILL NOTICE TO CLAIMANTS THIS IS NOT A BILL

RE: SUNSTAR HEALTH PLAN, INC.

Civil Action: 99-6705
2nd Judicial Circuit Court
Leon County, Florida

OBJECTION FILING DEADLINE:

01/01/2004

THIS IS NOT A BILL. SunStar Health Plan, Inc. ("SunStar") was declared financially insolvent and is in liquidation proceedings before the Circuit Court, Leon County, Tallahassee, Florida. The Court appointed the Florida Department of Insurance as the Receiver of SunStar. The purpose of this Notice to Claimants is to inform you of the Receiver's final recommendations to the Circuit Court concerning the classifications and amounts on a claim filed by you in the receivership estate of SunStar. To obtain a copy of the court order approving the Receiver's recommendation, please go to the Receiver's website at www.floridainsurancereceiver.org or send a written request for the order to the address below. The information on the attached Claim Evaluation Summary reflects the Receiver's evaluation of your claim, including the "Amount Recommended" and the "Class" or "Priority" of your claim.

The "Class" or "Priority" of your claim can affect the amount of money you may receive from the SunStar estate. Please be advised that the assets in the Receivership estate of SunStar are not sufficient to fund a distribution payment to all claimants. Florida Statute 631.271, "Priority of Claims", defines the classification of claims. (See F.S. 631.271 on reverse side of this form.) Every claim in each class, beginning with Class 1, must be paid in full before the members of the next class may receive any payment. Below is a brief description of the class of claims being reported to the Court:

- Class 1 Cost & expenses of the Receiver and state guaranty funds
- Class 2 Loss claims covered by the policy (claims by subscribers for reimbursement of expenses which should have been paid by the HMO)
- Class 3 Refund of unearned premium on non-assessable policies
- Class 4 Claims of the Federal Government
- Class 5 Claims of employees
- Class 6 Claims of general creditors (claims by providers)
- Class 7 Claims of any state or local government
- Class 8 Claims filed late
- Class 9 Surplus or contribution notes & refunds on assessable policies
- Class 10 Claims of shareholders or other owners

PLEASE review the attached Claim Evaluation Summary, including the amount on the line reading "Amount Recommended" and the "Priority of Claim" section. If you agree with the amount recommended and the class/priority, no further action on your part is necessary.

If, on the other hand, you object to the recommended amount or to the assigned class of your claim, YOU MUST FILE AN OBJECTION. If your class/priority has been identified as Class 7 through Class 10, you may object only to the Receiver's classification of your claim. If your claim was late filed (Class 8), you may object only to the Receiver's classification of your claim. All objections must be postmarked before the Objection Filing Deadline stated above.

OBJECTION PROCEDURE:

If you are filing an objection, please follow the procedure below:

1. State in detail all legal and factual reasons for your objection. At the top of your statement, include the following information: "Civil Action Number 99-6705", your identification number, correct address and telephone number.
2. Attach a copy of this notice to your objection.
3. Attach documentation to support your objection.
4. Mail the original objection package to the Clerk of Court, a copy to the Receiver at the address below, and keep a copy for yourself.
5. Once your objection is filed, the Receiver will evaluate the materials you submitted and you will be contacted regarding your objection. If your objection cannot be resolved, a hearing will be scheduled before the Circuit Court, Leon County, Florida.

YOUR OBJECTION MUST BE FILED WITH BOTH THE RECEIVER AND THE CLERK OF COURT, SECOND JUDICIAL CIRCUIT, LEON COUNTY COURT HOUSE, 301 S. MONROE STREET, TALLAHASSEE, FLORIDA 32301. YOUR OBJECTION MUST BE POSTMARKED BY THE DEADLINE GIVEN ABOVE. THE RECEIVER SUGGESTS THAT YOU SEND YOUR OBJECTION BY CERTIFIED MAIL, RETURN RECEIPT REQUESTED.

NOTE: Any distribution will be made on a pro-rata basis. If a distribution is made, you may not receive the full amount recommended for your claim. Depending on the assets available for distribution, you and other claimants in your classification may only receive a percentage of the amount recommended on your claim (i.e. 25% equals 25 cents on the dollar).

If a distribution is made, the payee(s) name(s) on the claim check will be the same as the name(s) appearing on the Claim Evaluation Summary. If the information on this form is incorrect, or becomes incorrect in the future, it is your responsibility to notify the Receiver and document any changes.

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**FLORIDA DEPARTMENT OF FINANCIAL SERVICES
RECEIVER FOR
SUNSTAR HEALTH PLAN, INC.**

FLORIDA STATUTE 631.271 Priority of claims

631.271 Priority of claims. —

- (1) The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is set forth in this subsection. Every claim in each class shall be paid in full or adequate funds shall be retained for such payment before the members of the next class may receive any payment. No subclasses may be established within any class. The order of distribution of claims shall be:
- (a) Class 1. —
 - 1. All of the receiver's costs and expenses of administration.
 - 2. All of the expenses of a guaranty association or foreign guaranty association in handling claims.
 - (b) Class 2. — All claims under policies for losses incurred, including third-party claims, all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which claims are not under policies, and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values, shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, may not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to her or his employee may be treated as a gratuity.
 - (c) Class 3. — Claims under nonassessable policies for unearned premiums or premium refunds.
 - (d) Class 4. — Claims of the Federal Government.
 - (e) Class 5. — Debts due to employees for services performed, to the extent that the debts do not exceed \$2,000 for each employee and represent payment for services performed within 6 months before the filing of the petition for liquidation. Officers and directors are not entitled to the benefit of this priority. This priority is in lieu of any other similar priority that is authorized by law as to wages or compensation of employees.
 - (f) Class 6. — Claims of general creditors.
 - (g) Class 7. — Claims of any state or local government. Claims, including those of any state or local government for a penalty or forfeiture, shall be allowed in this class, but only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under paragraph (j).
 - (h) Class 8. — Claims filed after the time specified in ss. 631.181(3), except when ordered otherwise by the court to prevent manifest injustice, or any claims other than claims under paragraph (i) or under paragraph (j).
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