FLORIDA DEPARTMENT OF FINANCIAL SERVICES, RECEIVER
FLORIDA SPECIALTY INSURANCE COMPANY
February 25, 2020
PROOF OF CLAIM FORM

RCN: 553 xxxxxx x
XXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXXXXXXX

POLICY HOLDER:	XXXXXXXXXXXXXXX
POLICY NUMBER:	XXXXXXXXX
CLAIM NUMBER:	XXXXXXXXX
CLAIMANT TYPE:	LOSS CLAIMS
DATE OF LOSS:	XX/XX/XXXX*
CLAIM REFERENCE:	
CIVIL ACTION NUMBER:	2019 CA 002328
EMAIL:	XXXXXXXXX@XXXXX.XXX

** Date of Liquidation is the default date where date of loss is not known or not applicable.*

CLAIMS FILING DEADLINE: 10/2/2020

The Florida Department of Financial Services as Receiver (Department) has been directed by Court Order to liquidate the above company. A copy of the Court Order can be obtained at the Department's website: http://www.myfloridacfo.com/division/receiver. You have been identified as someone who might have a claim against this company. **If you have no claim, please ignore this form.** If you have a claim, you must fill out this form according to the instructions on the back of this form and return it to the Department no later than the claims filing deadline indicated above. Failure to complete and return this form to the Department by the claims deadline may result in your claim being denied in full or in part.

PLEASE PRINT OR TYPE THIS SECTION

If the mailing address above is incorrect, please complete the address information below:

Name or Business Name	**XXXXXXXXXXX**				
Address1					
Address2					
City		**ST**		**Zip**	-

Date of Birth (*individuals only*):	/ /	**Do you have a master claim?** ☐ **Yes** ☐ **No** **You may have a master claim if you are an attorney, adjuster, medical provider, premium finance company, etc. Refer to instruction #2 on the back of this form for further information.**

Email Address:	**Daytime Phone:** **( ) -**
Total Amount of Claim: **(amount must be documented, see back of page for instructions)**	**$**

Is this a Secured Claim? ☐ **Yes** ☐ **No**
(A secured claim is any claim secured by a mortgage, trust deed, security agreement, etc. Documentation must be provided.)

Is this a FEDERAL GOVERNMENT claim? ☐ **Yes** ☐ **No**

Are you receiving or eligible for MEDICARE? ☐ **Yes** ☐ **No**

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 information contained on this form as well as all attachments are true and correct to the best of my knowledge and that the sum claimed is justly owed and that there is no setoff, counterclaim, or defense to the claim. The filing of a claim in the receivership proceeding is a release of the insured to the extent of coverage provided by the insolvent insurance company [Section 631.193, Florida Statutes].

X_____ ___/___/___ _____
Signature of/for Claimant **Date Signed** **Printed Name of Person Signing & Title (if signing for business)**

X_____ **Relationship of person signing this form to the above named claimant if other than the claimant.**