GEORGIA RESTAURANT MUTUAL CAPTIVE INSURANCE COMPANY, IN LIQUIDATION

PROOF OF CLAIM NO._____
DATE RECEIVED: _____

READ ALL MATERIALS CAREFULLY BEFORE COMPLETING THIS FORM – COMPLETE ALL SECTIONS – FILL IN ALL BLANKS – PLEASE PRINT CAREFULLY OR TYPE

Name of claimant

Address of claimant

Phone No: xxx-xxx-xxxx

If applicable, name of Georgia Restaurant Mutual Captive Insurance Company policyholder and policy number.

Policyholder Name:
Policy Number:

This claim is for:

- ☐ Loss under policy (Claim by insured of Georgia Restaurant for policy benefits)
- ☐ Unearned premium refund (Portion of paid premium not earned due or retro or audit adjustment)
- ☐ General Creditor (Attorney fees, Adjuster fees, Vendors, Landlords, Lessors, Consultants, Cedants, & Reinsurers)
- ☐ All Other (Describe)

In the space below give a concise statement of facts giving rise to your claim:

_____

_____

_____

AMOUNT OF CLAIM: $ _____

ATTACH COPIES OF ANY SUPPORTING DOCUMENTS SUCH AS CORRESPONDENCE, LAWSUITS, JUDGEMENTS, PREMIUM RECEIPTS, CANCELED CHECKS, ETC.

State of_____ County of_____

I HEREBY SWEAR OR AFFIRM UNDER PENALTY OR PERJURY THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE STATEMENTS AND ATTACHED SUPPORTING DOCUMENTS IN THIS CLAIM ARE TRUE AND CORRECT.

X _____
Claimant's Signature Date

_____Notary Public

My Commission Expires:_____

NOTICE: ALL CLAIMS MUST BE RECEIVED BY THE LIQUIDATOR AT THE FOLLOWING ADDRESS ON OR BEFORE March 21, 2011, OR BE FOREVER BARRED.

Office of Insurance & Safety Fire Commissioner
ATTN: CHRIS TAYLOR / REGULATORY SERVICES DIVISION
2 Martin Luther King, Jr. Drive
Suite 604, West Tower
Atlanta, Georgia 30334
PHONE (404) 656-2074