



DIFP

Department of Insurance,
Financial Institutions &
Professional Registration

Proof of Claim Creditor's Statement

OZARK BENEFIT ASSOCIATION LIFE INSURANCE CO. (OBA)

www.insurance.mo.gov/oba

573-522-6115

DEADLINE FOR FILING THIS PROOF OF CLAIM WITH THE LIQUIDATOR IS APRIL 30, 2015, 5 P.M. CDT

INFORMATION ON CLAIMANT

SOCIAL SECURITY or
FEDERAL TAX ID NUMBER

NAME _____
LAST FIRST MIDDLE MAIDEN/ALIAS/NICKNAME
INITIAL

BUSINESS NAME _____

ADDRESS _____
STREET CITY COUNTY STATE ZIP CODE

Any claimant who has or may have a claim against Ozark Benefit Association Life Insurance Co. (OBA), other than a policyholder, insured or beneficiary, is required to file a completed Proof of Claim "POC" with the Liquidator to be

eligible to participate in any distribution of assets. The POC should be mailed so the Liquidator receives it on or before the Claims Bar Date of April 30, 2015, at 5 p.m. CDT. A separate POC must be filed for each claim.

Check the box that describes your claim. Provide all requested information where applicable. If your claim involves litigation, include the case name and number and the court or tribunal where the litigation is pending.

For your claim to be considered, you must attach all supporting documentation or fully describe such documentation if previously forwarded to OBA. You must send additional information as it becomes available.

- Claim by U.S. government (other than claims under policy or insurance contract).
Agency _____ Case/Matter No. _____
- Claim by a state or local government (other than claims under policy or insurance contract).
State/Locality _____ Case/Matter No. _____
- Claim of any other kind as a general creditor.
- Other.

AMOUNT FOR ABOVE CLAIM

Amount, as it now can be determined \$ _____

Describe the claim and how you computed the amount claimed. Print legibly in ink or type. Use additional, letter-sized sheets of paper, if necessary. Include in your description:

- Basis of claim, including consideration given for it;
- Identity and amount of any security on claim;
- Any payments made on debt (any payments already received on the claim and sources of payments);
- Any right of priority of payment or other specific rights asserted by you; and
- If claim is contingent on a future event. If so, describe the contingency.

OVER

ATTORNEY REPRESENTATION (If an attorney represents claimant regarding this claim, please give the following information):

ATTORNEY'S NAME _____ **FIRM** _____

STREET ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

MAILING ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

ATTORNEY'S CONTACT INFO _____ **FIRM'S FEDERAL TAX ID NUMBER** _____

PHONE _____ FAX _____ EMAIL _____

DECLARATION BY CLAIMANT

The undersigned hereby certifies, declares, deposes and states that: he or she has read this POC form and knows the contents; this claim in the amount stated above is justly owing to the Claimant; there is no setoff, counterclaim or defense to the claim; the matters set forth above and in any accompanying statements are true to the best of your knowledge, information and belief, and as to such matters, you believe them to be true; no payment of or on account of the aforesaid claim has been made except as indicated herein; the Claimant understands that the Liquidator may require supplemental information or evidence and may require testimony under oath or affidavits to support this claim and may obtain information or evidence in any regard to this claim.

By signing this POC below as the Claimant or on behalf of the Claimant, you acknowledge that: this document is a declaration and an application for a pecuniary benefit or other consideration made to the Missouri DIFP Director in his capacity as the Liquidator of OBA and to the Circuit Court of Cole County, Mo., in Case No. 19V019600476; and that making a false statement herein which you do not believe to be true may subject the signee to criminal prosecution and penalties for making a false declaration in violation of §575.060 RSMo, and other laws of the state of Missouri.

AS CLAIMANT **OR** ON BEHALF OF CLAIMANT _____ **DATE** _____

PRINT YOUR NAME AND TITLE, AND OFFICIAL CAPACITY OR RELATION TO CLAIMANT _____

PHONE _____ FAX _____ EMAIL _____ FILE REFERENCE NO. (IF ANY) _____

SIGNED AT _____ **CITY** _____ **COUNTY** _____ **STATE** _____

Please retain a copy for your records and mail the original of this POC to: OBA Receivership ● PO Box 690 ● Jefferson City, MO 65102

ALL CLAIMANTS MUST FILE
Claimants who are not OBA policyholders or beneficiaries must file POCs with the Liquidator to preserve any right to payment from OBA. There must be an original signature on the POC.

NON-WAIVER OF DEFENSES
The Liquidator's acceptance of this POC form is not intended to, nor does it constitute, any waiver or relinquishment by the Liquidator of any defense, setoff or counterclaim that he may have against any person, entity or governmental agency.

CHANGE OF ADDRESS
If your address changes after you send in your POC, you must provide the Liquidator with your new address. Failure to do so may result in a loss of rights to obtain a distribution on your claim or to object if the Liquidator denies your claim in whole or in part.