PROOF OF LOSS FORM FOR MEDICAL HEALTH ALLIANCE INSURANCE CO.

Dear Member of the Medical Health Alliance Association and Named Insured of Medical Health Alliance Insurance Co. - Please read the instructions carefully before completing all pages of this Proof of Loss form. The Named Insured or its authorized representative must complete each section in its entirety.

Named Insured:		Policy Number:	
Mailing Address:			
Contact Person:		Email Address:	
		Telephone Number:	
Name of Claimant (If not the Named Insured:		Date of Loss:	
Please provide a concise statement of the nature of your claim and of the facts giving rise to your claim (attach additional pages if necessary):			
Is there other insurance that may cover this claim? If "Yes," please provide the name of the insurer(s) and the policy number(s):			
Has a lawsuit or other legal action been instituted by anyone in conjunction with this claim? If "Yes," please provide the following information:			
1. Court or tribunal where filed:			
2. Case Number:			
3. Plaintiff(s):			
4. Defendant(s):			

Please attach all documentation supporting your claim to this Proof of Loss form and submit the Proof of Loss form to the address listed on the following page. For claims relating to economic loss,

supporting documentation may include documents such as financial statements, audit reports, and tax returns for both the period of the claimed loss and for earlier periods, as well as documentation necessary to support the nature and cause of the claimed loss described above. Your Insurer may require you to submit additional supporting documentation or other information before your claim will be allowed or paid.

After signing below, please submit this form and all supporting documentation to:

Alliance Captive Management, LLC
c/o Kevin Doherty, Esq.
Dickson Wright, PLLC
424 Church Street, Suite 800
Nashville, TN 37219.
kdoherty@dickinson-wright.com

and

Alliance Captive Management, LLC
Claims@AllianceCaptiveMgt.com

BY SIGNING BELOW, I HEREBY SWEAR OR AFFIRM UNDER PENALTY OF PERJURY THAT THE FACTS STATED IN THIS PROOF OF LOSS FORM ARE TRUE AND CORRECT TO THE BEST OF MY INFORMATION, KNOWLEDGE, AND BELIEF AND THAT I AM AUTHORIZED TO SUBMIT THIS CLAIM FORM ON BEHALF OF THE NAMED INSURED/CLAIMANT NAMED ABOVE. I ALSO AUTHORIZE ANY OTHER INSURANCE PLAN UNDER WHICH NAMED INSURED/CLAIMANT HAS COVERAGE TO DISCLOSE INFORMATION AS MAY BE NECESSARY TO EVALUATE MY CLAIM AND AUTHORIZE MY INSURER LISTED ABOVE TO DISCLOSE ANY SUCH INFORMATION TO ANY OTHER INSURANCE PLAN UNDER WHICH NAMED INSURED/CLAIMANT HAS COVERAGE.

By:	
Print Name:	
Title:	Date: