

# Guardian Healthcare Liquidating Trust

Post Office Box 8625, Columbia, SC 29202

November 22, 2010

## To: All Service Providers

Effective October 12, 2010, Guardian Healthcare, Inc. was placed in Rehabilitation. This was done for financial reasons. On October 22, 2010, an Amended Order of Rehabilitation was entered against Guardian. The Amended Order provides for a number of things which include the following:

- An assumption of the policyholder contracts by Sterling Life Insurance Company effective 11/1/2010
- Authorization of a Liquidating Trust to handle all claims and liabilities incurred prior to 11/1/2010
- Authorization to transfer all unpaid claims and liabilities as of 11/1/2010 into the Liquidating Trust along with all assets then existing or subsequently acquired
- Sets 12/31/2011 as the deadline for filing proof of claims with the Liquidating Trust

Enclosed is a Proof of Claim form along with instructions for you to complete and return if you have unpaid health claims with dates of service prior to 11/1/2010. Also enclosed is Attachment A which you may use to list any unpaid health claims. You may attach a UB or 1500 form for each unpaid health claim to the Proof of Claim rather than complete Attachment A. If you later discover additional unpaid health claims, you may amend your Proof of Claim any time prior to 12/31/2011.

If you have filed health claims with Guardian per the instructions on the member's insurance card (P O Box 4196, Scranton, PA 18505), you do not need to file them again. If you have not yet filed your health claims, please do so immediately. It is necessary for all unpaid health claims to be filed in order for the Liquidating Trust to get the correct adjudicated amount that would be due to you under the policy.

If you have a claim for amounts that constitute underpayment of prior claims, please complete a separate Proof of Claim for that amount and attach to it a list of the claims that you believe were underpaid. Please include all of the information requested on Attachment A and add a column for the amount you were originally paid as well as a column for the underpayment amount you are seeking to recover.

Once your Proof of Claim is filed, you will receive an acknowledgement from the Liquidating Trust. At a future time you will be sent a letter giving details of the amount approved under your Proof of Claim. That letter will include instructions on actions you must take if you disagree with the amount approved.

The Liquidating Trust will handle only health claims with dates of service prior to 11/1/2010. Health claims with a date of service 11/1/2010 and after are the responsibility of Sterling Life Insurance Company. Do not include them on your Proof of Claim form. Continue to file these claims as you have in the past.

The Amended Rehabilitation Plan and other documents may be found at <http://doi.sc.gov/legal/Pages/receivershipcompanies.aspx>. Please note that any address changes, questions, or other comments must be made in writing to the above address.

# GUARDIAN HEALTHCARE LIQUIDATING TRUST

## PROOF OF CLAIM

**DEADLINE FOR FILING OF THIS PROOF OF CLAIM IS DECEMBER 31, 2011**  
**READ THE INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS FORM**

CLAIMANT'S NAME AND ADDRESS (Person Filing Claim)

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

*ALL DOCUMENTATION TO SUPPORT YOUR CLAIM MUST BE ATTACHED  
TO THE PROOF OF CLAIM IN ORDER FOR IT TO BE CONSIDERED*

### CLAIM IS FOR (CHECK APPROPRIATE BOX)

#### POLICYHOLDERS

- Claim is made for a specific loss or occurrence arising under the coverage of the policy (identify each such loss or occurrence).
- Claim is made for the return of unearned premium due to early cancellation. Was premium financed? \_\_\_ Yes \_\_\_ No  
If "yes," provide details of premium financing, including the name of the finance company, on a separate sheet.  
Amount of Premium/Consideration paid to date \_\_\_\_\_. You must attach copies of cancelled checks or other evidence of your payment of premiums.

#### CLAIMANTS (Other than Policyholders)

- Claim is made against a policyholder/insured of the above-named company. If claim arises from an accident please provide a description of the accident, police reports if available, medical bills, repair estimates or bills. Please provide sufficient information for the claim to be evaluated both as to fault and amount of damages claimed.
- Claim is made by an attorney for unpaid legal expenses.
- Claim is made by adjuster for expenses of adjusting a claim.
- Claim is made by an agent or broker.
- Claim is made by a general creditor for unpaid invoices.
- All Other Claimants (On a separate sheet, describe nature of claim and the consideration given for it.)

**TOTAL AMOUNT OF CLAIM** \_\_\_\_\_

If the amount of the claim is unknown, insert the words "Unstated Amount." You may amend the amount of your claim until the final date of adjudication or court-established bar date to do so.

No part of this debt has been paid, except \_\_\_\_\_

There are no setoffs or counterclaims to this debt, except \_\_\_\_\_

There is no security for the debt, except \_\_\_\_\_

#### STATUS OF CLAIM

- Claim is based on court judgment or settlement (attach order or agreement)
- Claim is currently pending in court (provide details and documentation)
- Claim has been filed with Guardian's third party administrator (TMG)
- Other insurance is available to cover this claim (provide details of other insurance policies)

COMPLETE THIS SECTION FOR ADDRESS CHANGE ONLY	NAME AND ADDRESS OF YOUR ATTORNEY (IF ANY)
Name	Name
Address	Address
City, State, ZIP	City, State, ZIP
Telephone	Telephone

The undersigned subscribes and affirms as true under the penalties of perjury as follows: that he/she has read the foregoing Proof of Claim and knows the contents thereof; that this claim is justly owing to the claimant and that there is no setoff, counterclaim, or defense to the claim thereto except as above stated; that the matters set forth above and in any accompanying documents are true to the best of his/her knowledge and belief; that no payment of or on account of the aforesaid claim has been made to you except as above-stated.

Claimant Telephone (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
Print or Type Name of Claimant, Partner, Officer, Legal Representative

\_\_\_\_\_  
Social Security Number or FEIN of Claimant

\_\_\_\_\_  
Signature of Individual, Partner, Officer, or Legal Representative

**SEE INSTRUCTIONS ON THE REVERSE SIDE FOR MAILING AND OTHER INSTRUCTIONS**

**IMPORTANT – READ CAREFULLY**  
**INSTRUCTIONS FOR COMPLETING AND FILING A PROOF OF CLAIM**  
**IN THE GUARDIAN HEALTHCARE LIQUIDATING TRUST**

1. GUARDIAN HEALTHCARE, INC. was determined to be insolvent and a Rehabilitation Order was issued by the Richland County Court of Common Pleas of South Carolina in case number 10-CP-40-7093 on October 12, 2010.
2. To have a claim considered in this liquidating trust proceeding, this Proof of Claim must be completed in detail. Information provided must be either printed or typewritten. You should file a separate Proof of Claim for each type of claim that is known to you. Attach additional sheets as necessary for any response. It is important that full documentation for any claim be submitted. **IF YOU FAIL TO ADEQUATELY DESCRIBE AND DOCUMENT YOUR CLAIM, YOUR CLAIM MAY BE REJECTED OR DENIED.**
3. **FILING INFORMATION:**
  - a. You must complete and return this form even if your claim already has been filed with Guardian.
  - b. Check the appropriate box, enter the amount claimed, and provide full documentation to support the claim.
  - c. If your claim is for a specific loss claim, you must provide an explanation of the loss being asserted. If your claim is for a loss that already has a claim number established by Guardian, please include the claim number on your correspondence.
  - d. If your claim is for the return of unearned premium, you must submit all documentation evidencing proof of premium payment.
  - e. If your claim is for rent, services, supplies, legal services, adjustment services, equipment or any supplies, equipment and services provided to Guardian, then provide a detailed description including dates of service, details of contract and an itemization of charges.
4. **THE PERSON FILING THIS PROOF OF CLAIM** (the Claimant) must fill in his/her Social Security or FEIN number, phone number, and must sign and date the Proof of Claim. Claims filed by entities must be signed by an authorized representative of the entity. If an attorney represents you in this matter, you must also provide your attorney's name and address in the space provided.
5. All written documents supporting your claim must be filed with your Proof of Claim. If such documents are lost or destroyed, a statement of that fact and the circumstances of such loss or destruction must be filed under oath.
6. **THE DEADLINE FOR FILING CLAIMS IS DECEMBER 31, 2011.** Timely filing of a Proof of Claim should not be construed to mean that payment of your claim will be made.
7. **CHANGE OF ADDRESS:** If you move after sending in your Proof of Claim form, you are responsible for providing a current address. Failure to do so may result in your claim being barred from participating in any distribution of assets.
8. **THE COMPLETED PROOF OF CLAIM** form, properly signed and dated, should be mailed with supporting documentation to:

**GUARDIAN HEALTHCARE LIQUIDATING TRUST**  
**POST OFFICE BOX 8625**  
**COLUMBIA, SOUTH CAROLINA 29202**

9. **GENERAL INFORMATION:** Your claim will be reviewed once it is returned to us. After all claims have been evaluated and approved by the Court, allowed claims will be paid by priority levels established under South Carolina law and to the extent the liquidating trust has available funds. We will not know the distribution percentage that can be paid on any individual claim until all claims are evaluated and all assets converted to cash. This process may take a number of years after the deadline for filing a Proof of Claim has passed, and we cannot state at this time whether any distribution of assets will be made on allowed claims.
10. You must complete and return the enclosed W-9 form with your Proof of Claim.

**FILING A PROOF OF CLAIM DOES NOT BY ITSELF GUARANTEE COVERAGE**  
**OR ANY REFUND OF PREMIUM TO POLICYHOLDERS**

**MAKE AND KEEP A COPY FOR YOUR RECORDS**



## Request for Taxpayer Identification Number and Certification

Give form to the  
 requester. Do not  
 send to the IRS.

Print or type  
 See Specific Instructions on page 2.

Name (as shown on your income tax return)	
Business name, if different from above	
Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ ..... <input type="checkbox"/> Exempt payee <input type="checkbox"/> Other (see instructions) ▶	
Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
City, state, and ZIP code	
List account number(s) here (optional)	

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or
Employer identification number

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

#### Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,