To Be Completed by SDR

POC # ______________________
Claim # _____________________
Date Received _______________

Filing Deadline:
December 28, 2020
11:59 p.m. CDT

CAPSON PHYSICIANS INSURANCE COMPANY
PROOF OF CLAIM

Return this completed Proof of Claim form and any supporting documents. A Proof of Claim must be **received** by the SDR no later than **December 28, 2020, 11:59 p.m. CDT** at one of the addresses shown below.

BY MAIL:
CANTILO & BENNETT, L.L.P.
Special Deputy Receiver
Capson Physicians Insurance Company
ATTENTION: CLAIMS
P.O. Box 184
Austin, Texas 78767

BY COURIER OR HAND DELIVERY:
CANTILO & BENNETT, L.L.P.
Special Deputy Receiver
Capson Physicians Insurance Company
ATTENTION: CLAIMS
11401 Century Oaks Terrace, Suite 300
Austin, Texas 78758

Please read the Proof of Claim instructions carefully before completing this Proof of Claim. Please print or type.

______________________________ $______________
Name of Claimant — Total Amount of Claim

______________________________ ______________
Street Address — Soc. Sec. or Tax ID Number

______________________________ ______________
City State Zip — Telephone Number

______________________________ ______________
E-mail Address — Facsimile Number

If the claimant is represented by an attorney, please complete the following section, and attach a copy of the Power of Attorney:

______________________________ ______________
Name of Attorney — State Bar No.

______________________________ ______________
Name of Law Firm — Tax ID Number

______________________________ ______________
Street Address — Telephone Number

______________________________ ______________
City State Zip — Facsimile Number

____
E-mail Address

Provide an explanation of your claim below, and state if there is any security on the claim or any payments that have been made on the claim. Attach additional pages if necessary.

NOTE: ATTACH DOCUMENTATION TO SUPPORT YOUR CLAIM

AFFIRMATION OF CLAIMANT

Texas law requires the following statement in a Proof of Claim

Unless otherwise stated in this proof of claim:

I alone am entitled to file this claim. No others have an interest in this claim. No payments have been made on the claim. No third party is liable on this debt. The sum claimed is justly owing, and there is no set-off counterclaim, or defense to the claim. I declare, under penalty of perjury, that all of the statements made in this Proof of Claim and all documents attached to this form are true, complete, and correct. If I am making a claim against a person insured by Capson Physicians Insurance Company, I understand that I am waiving any right to pursue the personal assets of that person, to the extent of the coverage and limits provided by the policy issued by Capson Physicians Insurance Company.

____
Signature

____
Print Name

State of ______________________________

County of ____________________________

The foregoing instrument was acknowledged before me this _________ day of ________________ 20___, by __________________________________, who has executed this instrument on such individual's own behalf, who is personally known to me or who has produced a Driver License or other information as identification.

____
Notary Public

____
Printed Name

My Commission Expires: _______________

(NOTARY SEAL)