

Time Insurance Company (in Liquidation)

“PROOF OF CLAIM” INSTRUCTIONS

YOUR PROOF OF CLAIM MUST BE FILED IN ACCORDANCE WITH THESE INSTRUCTIONS AND POSTMARKED BY MARCH 1, 2023 (THE “**BAR DATE**”) FOR YOUR CLAIM TO BE TIMELY FILED PURSUANT TO WIS. STAT. § 645.61 AND THE LIQUIDATION ORDER. **FAILURE TO TIMELY RETURN THE COMPLETED PROOF OF CLAIM FORM IN ACCORDANCE WITH THESE INSTRUCTIONS WILL RESULT IN DENIAL OF YOUR CLAIM.**

1. General Instructions. Please print legibly in ink or type. All blanks must be completed; if requested information is not available, please mark the blank “not available.” **You must attach to your Proof of Claim all supporting documents, contracts, and invoices.** If documentation is voluminous, please attach a summary. If you have more than one claim, a Proof of Claim form must be completed and submitted for each claim. Retain a copy of your Proof of Claim form and any supporting documents that you submit. You may wish to keep proof of mailing or delivery as well.
2. Additional Pages. If the space provided for any item is inadequate, note “continued” in the appropriate place(s) and continue the item(s), preceded by the item number, on an additional 8½ x 11-inch sheet of paper. Be sure to attach securely all additional pages to the form before filing.
3. Setoffs or Counterclaims. Enter the amount of all payments or debts, if any, which you currently owe to Time.
4. Signatures. All claims must be signed by the claimant or someone authorized to act on the claimant’s behalf and having knowledge of the facts.
5. Change of Address. You are required to notify the Liquidator of address changes. Failure to do this may jeopardize your chance of receiving a recovery from Time.
6. Claim Processing Procedures. Claims will be adjudicated, as applicable, in accordance with Time’s business rules, policy or contract terms, and/or the Liquidation Order and other applicable Orders in Time’s liquidation.

EXCEPT FOR FILING THIS PROOF OF CLAIM, THE LIQUIDATION ORDER ENJOINS AND PROHIBITS ALL PERSONS AND ENTITIES, INCLUDING CREDITORS OF TIME, FROM COMMENCING OR PROSECUTING ANY ACTIONS, CLAIMS, LAWSUITS, ADMINISTRATIVE OR OTHER PROCEEDINGS AGAINST TIME, THE COMMISSIONER AS REHABILITATOR OF TIME, AND THE SPECIAL DEPUTY COMMISSIONER AND HIS ASSISTANTS.

7. Deadline (“Bar Date”) and Where to File the Proof of Claim. The completed and signed Proof of Claim form must be filed with the Liquidator by first class mail or overnight mail sent to the following address and postmarked on or before the Bar Date:

**Special Deputy Commissioner Mark Femal
Time Insurance Company (in Liquidation)
Strohm Ballweg, LLP
9701 Brader Way, Suite 301
Middleton, WI 53562**

Inquiries only:

Email: mfemalsdc@strohmballweg.com

NOTE: The Liquidator’s receipt of a Proof of Claim form does not constitute a waiver or relinquishment by the Liquidator or Time of any defense, setoff, or counterclaim that may exist against any person, entity, or governmental agency regarding any actions pursued or defended by the Liquidator on behalf of Time, its policyholders, contract holders, claimants, and/or creditors.

**Proof of Claim in the Matter of Time Insurance Company
(In Liquidation).**

For Office Use Only

Date Proof Received: _____

Proof of Claim #: _____

Dane Co. Circuit Court Case No. 2020-cv-1054

DEADLINE FOR FILING PROOF OF CLAIM IS MARCH 1, 2023.

PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM. EACH SECTION MUST BE FULLY COMPLETED. INSTRUCTIONS ARE ATTACHED. IF ADDITIONAL COPIES ARE NEEDED, PLEASE PHOTOCOPY OR DOWNLOAD THE FORM at <https://oci.wi.gov/Pages/Companies/LiquidationTimeInsCo.aspx>.

FILE A SEPARATE "PROOF OF CLAIM" FORM FOR EACH UNRELATED CLAIM.

PERSON OR ENTITY MAKING CLAIM AGAINST TIME INSURANCE COMPANY ("Time"):

1. NAME: _____

2. MAILING ADDRESS: _____

3. TELEPHONE NUMBER (DAYTIME): _____

4. CLAIM IS FROM: (Check "X" or specify below)

A. Trade Creditor or Vendor
Social Security or Federal Tax I.D. Number: _____

B. Agent/Commission
Agent I.D. Number: _____

C. Insured
Policyholder I.D. Number: _____; Social Security Number of Payee: _____

D. All other claims - please describe & provide Social Security or Federal Tax I.D. Number:

5. In the space below give a CONCISE STATEMENT of the FACTS giving rise to your claim. Attach additional sheets if required.

6. **NUMBER OF RELATED CLAIMS: _____ AND TOTAL AMOUNT OF YOUR CLAIMS:**

\$ _____.

If amount of claim is unknown, insert words "Unstated Amount." You may amend your timely filed claim up until the final date that your claim is adjudicated. Please attach all documents, contracts, and invoices supporting your claim. If they are voluminous, please attach a summary.

7. No part of the debt has been paid, except: _____

8. There are no setoffs, counterclaims, or defenses to the debt, except: _____

9. There is no security for the claim, except (identify the security and the amount secured): _____

10. Legal and factual basis for any claimed right of priority of payment: _____

The undersigned claimant affirms that the representations and information contained in this Proof of Claim are true and correct to the best of his, her, or its knowledge and that the claimed debt is justly owing.

Dated: _____

Claimant's Name (please print or type)

Signature of Individual, Partner or Officer

Claimant's Attorney (if any): _____