

**PROOF OF CLAIM IN THE MATTER OF WISCONSIN REINSURANCE CORPORATION,
IN LIQUIDATION**

Case No. 2023-CV-001310

For Office Use Only

Liquidator

Claim No: _____

Date Claim

Received: _____

DEADLINE FOR FILING PROOF OF CLAIM IS JULY 1, 2024

File a separate Proof of Claim for each claim.

READ CAREFULLY BEFORE COMPLETING THIS FORM – PLEASE PRINT

Claimant Information:

Name: _____

Policy Number: _____

Insured: _____

Street Address _____

Claim Number: _____

City _____

State _____

Zip Code _____

Date of Loss: _____

Telephone: () _____

Email Address _____

(If you are represented by an attorney in this matter, please attach a separate sheet with the attorney's name, address, and telephone number.)

Claim Information:

EACH PROOF OF CLAIM MUST ATTACH ALL SUPPORTING DOCUMENTATION IN ORDER TO BE CONSIDERED.

AMOUNT OF CLAIM (show amount remaining due after reduction for all partial payments received): \$ _____

Attach a statement briefly explaining the nature of your claim. If your claim arises out of an accident or other loss, you must include the date and location of the accident or loss. If your claim arises out of an insurance policy issued by Wisconsin Reinsurance Corporation provide the name of the person or entity insured by Wisconsin Reinsurance Corporation and any existing claim number.

Attach a list of all other insurance policies providing coverage or other sources for possible payment for this claim. Include the name of the insurance company, policy number, and claim number, if applicable.

Additional Information:

Are you a resident of the State of Wisconsin? (Circle one)

Yes

No

Is there security on your claim?
(Circle one, and attach description if applicable)

Yes

No

Is there a written contract, other than an insurance policy involved?
(Circle one, and if yes, attach description and any applicable documentation)

Yes

No

UNDER PENALTIES OF LAW, I STATE THAT THE FACTS AS SET FORTH IN THIS CLAIM ARE TRUE, THAT THE SUM CLAIMED IS JUSTLY OWING AND THAT THERE IS NO SET-OFF, COUNTERCLAIM OR DEFENSE TO THE CLAIM SUBMITTED, OTHER THAN AS SET FORTH HEREIN.

Claimant's Name (Please Print)

Signature of Claimant (Individual, Partner, or Officer)

RETAIN A COPY FOR YOUR RECORDS

RETURN TO: Special Deputy Liquidator, c/o Wisconsin Reinsurance Corporation in Liquidation
Att. Mr. Justin Schrader, Special Deputy Commissioner
2810 City View Dr.
Madison, WI 53718

SEE INSTRUCTIONS TO COMPLETE AND SUBMIT PROOF OF CLAIM FORM