NOTICE TO GROUPS AND INDIVIDUALS, VENDORS, AGENTS/BROKERS AND GENERAL CREDITORS OF THE MARCH 31, 2016 DEADLINE FOR FILING CLAIMS

LOUISIANA HEALTH COOPERATIVE, INC. IN REHABILITATION
DOCKET NUMBER 641 928 Section 26
19th JUDICIAL DISTRICT COURT FOR THE PARISH OF EAST BATON ROUGE

THIS NOTICE CONTAINS IMPORTANT INFORMATION WHICH AFFECTS YOUR LEGAL RIGHTS

On September 31, 2015, the 19th Judicial District Court for the Parish of East Baton Rouge, State of Louisiana in case number 641 928 entered an order of permanent rehabilitation for Louisiana Health Cooperative, Inc. in Rehabilitation ("LAHC").

On January 28, 2016, the 19th Judicial District Court for the Parish of East Baton Rouge, State of Louisiana, entered an order requiring that all LAHC policyholders, members, enrollees and subscribers, all LAHC vendors, all LAHC agents/brokers, and all known LAHC creditors file any and all claims on the LAHC claim form provided on or before March 31, 2016.

LEGAL NOTICE

YOU ARE HEREBY NOTIFIED THAT YOU HAVE UNTIL MARCH 31, 2016 TO FILE YOUR CLAIM WITH LOUISIANA HEALTH COOPERATIVE, INC. IN REHABILITATION.

ANY CLAIM RECEIVED AFTER MARCH 31, 2016 will be considered untimely and not currently eligible for payment, unless for good cause shown and at the discretion of the LAHC Receiver.

Please fill out the attached form and return it to LAHC on or before March 31, 2016.

STAY AND ABATEMENT OF LEGAL PROCEEDINGS

Pursuant to the September 21, 2015 order of the 19th Judicial District Court, all suits and seizures against LAHC and the enrollees, subscribers, members and/or policyholders of LAHC are stayed. The order prohibits the commencement or maintenance of any action or proceeding against LAHC.

FURTHER INFORMATION

If you want further information about the Louisiana Health Cooperative and/or this legal proceeding, you may wish to contact your own legal counsel or

Louisiana Health Cooperative, Inc. in Receivership
3445 N. Causeway Boulevard, Suite 800
Metairie, LA 70002
1-855-475-3702
www.mylahc.org

Further information is available on line at http://www.ldi.la.gov/industry/financial-regulation/receivership/louisiana-health-cooperative

CLAIM ADJUDICATION AND DETERMINATION FORM
LOUISIANA HEALTH COOPERATIVE, INC. in REHABILITATION ("LAHC") CLAIM FORM

Name: _____
Address: _____
Phone Number: _____
Tax Identification/Social Security Number: _____
Policy Number: _____
INSURED: _____
Date of Claim: _____

AMOUNT OF CLAIM: $ _____

To participate in any distributions on timely claims, all of your claims must be received by LAHC on or before the **Claim Filing Deadline of MARCH 31, 2016. If you are unable to file your claim by that date, please contact LAHC and discuss your situation, as no late filed claims will be considered, unless for good cause shown and at the discretion of the LAHC Receiver.**

No persons having a contingent claim against LAHC shall participate in any distribution of assets **unless such claims are received by the Receiver on or before the Claim Filing Deadline of March 31, 2016.**

EACH CLAIM FORM MUST HAVE ATTACHED ALL SUPPORTING DOCUMENTATION
OR REFER TO DOCUMENTATION PREVIOUSLY FILED WITH LAHC TO BE CONSIDERED.

CHECK EACH APPLICABLE BASIS OF YOUR CLAIM AND LIST EACH AMOUNT IN THE FAR RIGHT COLUMN:

POLICYHOLDERS / INSUREDS:
☐ Unpaid benefits arising under the coverage of a LAHC policy or contract. $_____
☐ Unearned or refund premiums related to a LAHC policy. $_____
CLAIMANTS (Other than Policy holders / Insureds):
☐ U.S. Government claims. $ _____
☐ Secured claim. $ _____
☐ Salary or wages for services performed. $ _____
☐ Governmental entity claim for penalties or forfeitures. $ _____
☐ Unpaid legal or professional expenses. $ _____
☐ Unpaid commissions. $ _____
☐ Unpaid vendor invoices. $ _____
☐ All other claimants (On a separate sheet describe nature, amount and consideration related to each claim). $ _____
TOTAL AMOUNT OF CLAIM $ _____

Do you assert this claim is entitled to priority under La. R.S. 22:254 or La. R.S. 22: 2025? ☐ Yes ☐ No.
If yes, identify the applicable subsection and reason for the priority amount. Use separate sheets as needed.

Describe any prior payments made on the debt: Use separate sheets as needed.

Are there set-offs, counterclaims or defenses to the debt? ☐ Yes ☐ No.
If yes, describe here: Use separate sheets as needed.

Is there security for the debt? ☐ Yes ☐ No.
If yes, describe the underlying security and its estimated current value:
Use separate sheets as needed.

STATUS OF CLAIM:

☐ Claim is based on a court judgment or settlement, dated: _____
(attach judgment or agreement if not previously provided to LAHC).
☐ Claim is currently pending in court
(provide details and documentation or reference items previously provided to LAHC).
☐ Claim has not been filed in court.

Undersigned subscribes and affirms as true as follows in filing this claim: That he/she has read the foregoing Claim form and knows the contents thereof; that this claim is justly owing to claimant; that there are no setoffs, counterclaims or defense to the claim, and that the matters set forth in any accompanying documents are true to the best of his/her knowledge and belief.

Sworn by me, Notary,
this __ day of _____ 2016.

_____
Notary Public
DATE SIGNED _____, 2016.

_____
NAME OF CLAIMANT (Please print or type)

_____
Signature of Individual, Partner or Officer

Home Telephone (____) _____

E-mail: _____

SEE REVERSE SIDE FOR INSTRUCTIONS

CLAIMS NOTICE

By Order of the 19th Judicial District Court for the Parish of East Baton Rouge, State of Louisiana, all persons who may have claims against Louisiana Health Cooperative, Inc. in Rehabilitation ("LAHC") shall present the same to the Receiver **by MARCH 31, 2016** through a LAHC claim form. A claim shall consist of a statement in writing, signed by the claimant, setting forth the claim, the consideration therefor, and whether any, and if so, what security are held therefor, and whether any, and if so, what payments have been made thereon, and that the sum claimed is justly owing from LAHC to the claimant. Whenever a claim is founded upon an instrument in writing, such instrument, unless lost or destroyed, shall be filed with the LAHC claim form, unless such was previously filed with LAHC. If such instrument is lost or destroyed, a statement of such fact and of the circumstances of such loss or destruction shall be filed under oath with the claim.

All claims must be submitted by **MARCH 31, 2016, unless for good cause shown and at the discretion of the LAHC Receiver.**

A written notice of approval or denial in whole or in part will be given to the claimant or counsel. Whenever the LAHC Receiver denies the claim in whole or in part and the claimant objects within 60 days to all or any portion of the contested amount, the LAHC Receiver will resolve the contested claim.

When all claims against LAHC are determined by the Receiver and approved by the Court, the Receiver will seek Court approval for payment based on available general assets. The amount of payment will depend on the percentage of total assets to total claims in each particular claims class. This process will take a number of months after the claims filing deadline.

LAHC's acceptance of this LAHC Claim form is not intended to nor does it constitute any waiver or relinquishment by LAHC of any defense, setoff or counterclaim that LAHC may have against any person, entity or governmental agency.

INSTRUCTIONS

Enlisting the help of an attorney is not required. However, if your claim is completed and/or submitted on your behalf by an attorney, please provide their contact information. If your claim is for policy benefits, please provide details. Attach copies of supporting documents (do not send original documents). If the documents are voluminous, attach a summary. If the documents are not available, please explain. If you have other types of claims against LAHC provide a brief explanation of each claim and the amount claimed.

You must sign the LAHC Claim form. Please retain a copy for your records and mail the original of the form to:

Louisiana Health Cooperative, Inc. in Receivership
3445 N. Causeway Boulevard, Suite 800
Metairie, LA 70002
1-855-475-3702

CHANGE OF ADDRESS

If you move after you send in your claim form, you must provide LAHC with your new address. Failure to do so may result in a loss of rights to obtain a distribution on your claim or to object to a denial in whole or in part of your claim.

GENERAL INFORMATION FOR HEALH CARE PROVIDERS

Medical providers should NOT use this form.

Claims for healthcare services MUST be submitted as they have been to LAHC in the normal course of business for processing and must be filed by March 31, 2016, unless for good cause shown and at the discretion of the LAHC Receiver.

Properly submitted health care claims (including all claims already filed) by health care providers will be considered sufficient to establish a claim with the LAHC Receiver for health care services without the need to file a formal LAHC Claim form.

Please note that filing duplicate claims previously received by LAHC will result in a charge of $10.00 per line for processing.

For questions, please call (855) 475-3702.

Further information is available on line at:
http://www.ldi.la.gov/industry/financial-regulation/receivership/louisiana-health-cooperative