

Date Proof Received: \_\_\_\_\_

Proof of Claim #: \_\_\_\_\_

**“PROOF OF CLAIM”**

**CONSUMERS MUTUAL INSURANCE OF MICHIGAN (In Liquidation)  
DEADLINE FOR FILING: AUGUST 10, 2016**

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 [www.michigan.gov/difs](http://www.michigan.gov/difs), then click on the Quick Link “Who We Regulate,” then “Receiverships,” then “Consumers Mutual Ins. of Michigan,” then “Proof of Claim Form.” FILE A SEPARATE “PROOF OF CLAIM” FORM FOR EACH UNRELATED CLAIM.

**PERSON OR ENTITY MAKING CLAIM AGAINST CONSUMERS MUTUAL INSURANCE OF MICHIGAN:**

1. NAME: \_\_\_\_\_

2. MAILING ADDRESS: \_\_\_\_\_

3. TELEPHONE NUMBER (DAYTIME): \_\_\_\_\_

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

A. ( ) Trade Creditor for amounts owed on open account - Social Security or Federal Tax I.D. Number: \_\_\_\_\_

B. ( ) Agent Commissions – Agent I.D. Number: \_\_\_\_\_

C. ( ) Insured (non-healthcare service) – Policyholder I.D. Number: \_\_\_\_\_  
Social Security Number of Payee: \_\_\_\_\_

D. ( ) All other claims – please describe & provide Social Security or Federal Tax I.D. Number: \_\_\_\_\_

E. **NOTE:** Healthcare providers and insureds should continue to submit claims for healthcare services to Consumers Mutual for processing in the normal course of business. DO NOT FILE THIS PROOF OF CLAIM FORM for healthcare services provided to a Consumers Mutual insured.

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 CLAIM(S):** \$ \_\_\_\_\_.

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 debt, 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. The claimant further understands that any statements or representations contained herein which knowingly present a false claim constitutes a criminal offense punishable under Michigan Law.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Claimant’s Name (please print or type)

Signature \_\_\_\_\_

Claimant’s Attorney (if any): \_\_\_\_\_

Title (if applicable) \_\_\_\_\_