AMERICAN FELLOWSHIP MUTUAL PROOF OF CLAIM FORM

Deadline for filing:

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 then click "Who We Regulate", then American Fellowship, then "Proof of Claim Form". File a separate "Proof of Claim" form for each unrelated claim.

FOR OFFICE USE ONLY	**Proof of Claim Number:**
Date Postmarked:	Date Received:
Part 1: CLAIMANT INFORMATION (Person Making Claim):	
Name:	Social Security/EIN/TIN#:
Address 1: Address 2: City: State: Zip Code: Country:	Date of Birth:_____ Telephone Number Home: ( )_____ Work: ( )_____
Does an attorney represent you? Yes ( ) No ( ) If yes, provide attorney's name, address & telephone number:	
Part 2: INSURED / POLICY INFORMATION	
Name of Insured:	Claimant/Patient:
Policy Number:	Claim Number:
Agent Name or Number:	Date of Loss:
Part 3: CLAIM INFORMATION	
Amount of Claim:	Date Claim Became Due:
Check the statement below that best describes your claim: _____ POLICYHOLDER OR THIRD PARTY CLAIM Claim by insured for POLICY BENEFITS or claim against an insured for POLICY BENEFITS. _____ RETURN OF UNEARNED PREMIUM OR OTHER PREMIUM REFUNDS Portion of paid premium not earned due to early cancellation of policy or audit adjustment.	_____ SECURED CLAIM _____ POLICYHOLDER COLLATERAL _____ CREDITOR Agents, Attorney fees, Vendors, Landlords, Lessors, Consultants, Cedants and Reinsurers _____ ALL OTHER Describe:
Describe the basis and nature of the claim and attach all documents supporting the claim. Attach additional page, if necessary.	
Is there other insurance that may cover this claim? Yes ( ) No ( ) If yes, provide the name of insurer(s) and policy number(s):	
Has a lawsuit or other legal action been instituted by anyone regarding this claim? Yes ( ) No ( ) If yes, provide the following: Court Where Filed: Date filed & Case Number: Plaintiff(s): Defendant(s):	
Have you received any payments on the claim which is the subject of this Proof of Claim from any source? If yes, specify the total amount received: $_____and identify all sources:	

CONTINUED ON REVERSE SIDE

Do you owe any money to the Company? If yes, specify the amount: $
And the reason:

Is this a secured claim? If yes, specify all security for such claim:

Is this claim contingent or unliquidated? If yes, specify the reason:

Part 4: AFFIRMATION

PROOF OF CLAIM
AMERICAN FELLOWSHIP MUTUAL INSURANCE COMPANY
In Liquidation (the "Company")
Ingham County Circuit Court, State of Michigan; Case No. 12-1173-CR

The undersigned subscribes and affirms as true under the penalties of perjury as follows: that he or she has read the foregoing Proof of Claim and knows the contents thereof; that this claim in total amount of $_____ against the Company is justly owing to the Claimant; that the matters set forth and in any accompanying statements and supporting documents are true and correct; that no payment of or on account of the aforesaid claim has been received except as above stated; and that there are no setoffs or counterclaims thereto except as above stated.

_____
Claimant (Signature)

_____
Title or Official Capacity (if any)

_____
Claimants Attorney (if applicable)

Date Signed: _____

IMPORTANT NOTICES

A. Proof of Claim must be properly signed and dated. Remember to attach all documentation.
B. **Deadline for filing Proof of Claims is December 12, 2013**.
C. If you have a change of address, you are required to inform the Liquidator at the address below of the new address in order to receive any payment that might be due**.**
D. Return your completed form to:

American Fellowship Mutual
Suite 200
25925 Telegraph Road
Southfield, MI 48033

E-Mail: proofofclaim@afmico.com
Fax: (248)-352-4921
Phone: 1-(800)-648-6329