GEORGIA PLUMBERS TRADE ASSOCIATION HEALTH PLAN
c/o Receivership Management Inc.
Claims Administrator
PO Box 2307
Brentwood, TN 37024
(615) 370-0051

NOTICE OF PROOF OF CLAIM PROCEDURE AND RELEASE

You have been identified as a former participant or a provider of medical services to a former participant of the Georgia Plumbers Trade Association Health Plan. As such a person, you have the opportunity to participate in the Proof of Claim Procedure, as authorized in the case of Hilda Solis, U.S. Secretary of Labor v. Marc Meixner, GPTA Benefits Group, Inc. et al., No. 1:07-cv-0595 before the United States District Court for the Northern District of Georgia (the "Court"). On July 20, 2009, the Court authorized the Successor Fiduciary to establish this Proof of Claim procedure.

YOU HAVE THE ABILITY TO RECEIVE PAYMENT FROM THE SETTLEMENT FUND FOR YOUR UNPAID CLAIMS THAT WERE INCURRED BETWEEN 2002 AND 2004 THROUGH THIS PROOF OF CLAIM PROCEDURE. THIS WILL BE YOUR ONLY OPPORTUNITY TO DO SO.

IF YOU WISH TO PARTICIPATE IN THIS PROOF OF CLAIM PROCEDURE, PLEASE REVIEW THE ENCLOSED INSTRUCTIONS AND COMPLETE THE INFORMATION AND PROOF OF CLAIM FORM AS INSTRUCTED. YOUR PROOF OF CLAIM FORM MUST BE MAILED TO THE SUCCESSOR FIDUCIARY AND POSTMARKED NO LATER THAN JANUARY 15, 2010. SHOULD YOU WISH CONFIRMATION OF OUR RECEIPT OF YOUR FORM, WE SUGGEST YOU MAIL YOUR FORM CERTIFIED MAIL.

MAIL YOUR COMPLETED FORM TO:

GEORGIA PLUMBERS TRADE ASSOCIATION HEALTH PLAN
c/o Receivership Management Inc.
Claims Administrator
PO Box 2307
Brentwood, TN 37024

If you have any questions CALL Receivership Management Inc. at 615-370-0051

INSTRUCTIONS FOR COMPLETING PROOF OF CLAIM FORM
AGAINST
GEORGIA PLUMBERS TRADE ASSOCIATION HEALTH PLAN

Claims for medical services provided for the period 2002 through 2004.

For PARTICIPANTS – Covered Person Claim, Covered Person Claim for OOPE, Successor-in-Interest

Step 1: List the name of the hospital or doctor, the date of service, and the amount of the charge on the form where indicated.

Step 2A: CLAIM FOR REIMBURSMENT OF OUT OF POCKET EXPENSE. If the charge you list is a charge that you have paid be sure to list the billed amount on the Proof of Claim form and list the amount you have paid toward that medical charge. You must also submit evidence that you have paid the claim (i.e. photocopies of medical billing statements, invoices showing both the billed amount and the amount that has been paid and copies of receipts, cancelled checks (front and back) or credit card billing statements used to pay the medical bill.

Step 2B: CLAIM FOR PAYMENT OF UNPAID MEDICAL CLAIMS. If the charge you list is for a claim that you have not paid, include documentation from your medical provider that this medical claim is still outstanding. This documentation should include photocopies of billing invoice or statement.

Step 3: After listing the medical claims on the Proof of Claim form and the amount on each you are claiming, total those amounts you have listed and write that number in the blank marked "Total Amount Claimed." Sign the Proof of Claim form and have your signature notarized. Mail the Proof of Claim Form and supporting documentation to the address listed below.
****Participants: if your medical claims were discharged in bankruptcy you filed, please forward this form to your provider. They may still have collection rights against the plan for unpaid services which occurred during your enrollment with the GPTA Plan.***

For PROVIDERS – Provider Claim, Successor-in-Interest

Step 1: List the name of the patient, the date of the service, the service provided, and the amount charged on the Proof of Claim form.

Step 2: ATTACH SUPPORTING DOCUMENTATION All listed claims must be accompanied with all necessary supporting documentation (billing statement, HCFA 1500; UB92, etc.)

Step 3: COMPLETING THE PROOF OF CLAIM FORM After listing the medical claims on the Proof of Claim form and the amount on each you are claiming, total those amounts you have listed and write that number in the blank marked "Total Amount Claimed." Sign the Proof of Claim form and have your signature notarized. Mail the Proof of Claim Form and supporting documentation to the address listed below.

All Proof of Claim Forms must be postmarked no later than January 15, 2010 and mailed to:

GEORGIA PLUMBERS TRADE ASSOCIATION HEALTH PLAN
c/o Receivership Management Inc.
Claims Administrator
PO Box 2307
Brentwood, TN 37024

SHOULD YOU WISH CONFIRMATION OF OUR RECEIPT OF YOUR FORM, WE SUGGEST YOU MAIL YOUR FORM CERTIFIED MAIL.

PLEASE READ THIS FORM CAREFULLY AND NOTE THAT YOU ARE MAKING THE FOLLOWING STATEMENTS UNDER OATH:

PROOF OF CLAIM

AGAINST

THE GEORGIA PLUMBERS TRADE ASSOCIATION HEALTH PLAN

BEFORE ME, the undersigned Notary Public, appeared the person whose name is subscribed hereto, who states under oath that, after deducting all offsets and counterclaims, the above entity is indebted to her/him as follows:

(For Receiver's use only)

Claimant Name____ Claim No.________________
(Party who is executing this claim and to whom payment should be made)

Claimant Address____
(Street of Box Number) (City) (State) (Zip Code)

Contact Person______________________ Work Phone(   )_____-___________ Tax ID#________________

Name of Attorney (if applicable)______________________________________ Phone No.______________

Attorney Address____
(Street or Box No.) (City) (State) (Zip Code)

Covered Person Name:____________________________ Covered Person Soc.Sec.#____________________

Type of Claim (PLEASE CHECK ONE):

Covered Person________ Covered Person OPPE________ Successor-in-Interest to a Covered Person__________ Provider__________

Dates of Loss and Comment (add additional sheets if necessary) **Amount Claimed**

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Total Amount Claimed:______________________

That the above is TRUE & CORRECT, justly owed, and no part of the amount claimed has been paid by the Georgia Plumbers Trade Association Health Plan, or any other source. Should monies from other sources be disbursed, I will contact the Successor Fiduciary and report the amount.

That I verify, under penalty of perjury, to the best of my knowledge a) that I am the holder of the unpaid claim(s) noted above; b) that I was a participant who was covered by the Plan [a "covered person"]) OR I am a provider of medical services to a covered person; and c) that I have unpaid claims regarding the Plan.

____
Claimant Signature

SUBSCRIBED AND SWORN BEFORE ME, this _________day of______________________________,20____

____
Notary Public

My Commission Expires:____________________

____
Notary Name Typed/Printed

ALL CLAIMS MUST BE MAILED TO THE ADDRESS BELOW AND POSTMARKED NO LATER THAN JANUARY 15, 2010

Jeanne B. Bryant, Successor Fiduciary, P.O. Box 2307, Brentwood , TN 37024 (615) 370-0051

DEFINITIONS OF TERMS CONTAINED IN PROOF OF CLAIM FORM

Claimant Name........................... Person(s) or entity making claim against the plan

Claim Type.................................. SEE BELOW

Attorney Name and Address............. Only applies if your medical claim is in litigation or you are a Third Party Claimant

Comments Section........................... To be used for any additional information you wish to be known concerning your claim

Date of Loss................................. This is the time period in which medical charges arc unpaid

Amount Claimed............................. This is amount you are claiming against the Plan.

Claim Types:

Covered Person Claim...........................a claim by a Covered Person who received any Covered Services during the Period of 2002 thru 2004 which gave rise to an Unpaid Claim.

Covered Person Claim for OOPE............. a claim by a Covered Person who has paid out of pocket for any portion of an Unpaid Claim and have not been fully reimbursed all amounts to which such Covered Person is entitled under the terms of the Plan with respect to such amount paid out of pocket.

Provider Claim...................................Means with respect to any medical services the provision of which have given rise to an Unpaid Claim, any claim for payment by the provider of such services or the Successor-in-interest of any such provider.

Successor-in-Interest ....Means a Person's estate, legal representatives, heirs, successors or assigns, provided, however, that a provider of medical services who is an assignee of the rights of any Covered Person to payment for such services under the Plan shall be deemed a Successor-in-Interest of such Covered Person only if the provider has waived the right to assert, or is otherwise barred by law from asserting, any claim against the assignor Covered Person for payment with respect to such medical services.