**THE UNITED STATES VIRGIN ISLANDS**

**OFFICE OF THE LIEUTENANT GOVERNOR**

**DIVISION OF**

**BANKING, INSURANCE**

**AND FINANCIAL REGULATION**

PROOF OF CLAIM FORM

IN THE MATTER OF

REAL LEGACY ASSURANCE COMPANY, INC.

This form must be prepared in duplicate, notarized and filed with the Office of the Lieutenant Governor, Division of Banking, Insurance and Financial Regulation at one of the following addresses. Please note that execution of this form does **not** entitle you to receive payment. A determination on whether you are entitled to receive payment including how much payment you will receive, given the amount of funds available, will be made after all of the information, including all supporting documentation, is reviewed.

Nisky Center, 2nd Floor 7 & 8 King Street, 3rd Floor

St. Thomas, VI 00802 Christiansted, VI 00820

Telephone: (340) 774-7166 Telephone: (340) 773-6459

|  |  |
| --- | --- |
| Insured/Policyholder: |  |
| Policy No: |  |
| Policy Period: |  |
| Claimant: |  |
| I.D. No.: and Type |  |
| Date of Loss: |  |
| Type of Claim: | (Please check one) ❒ Original ❒Supplemental ❒Unearned Premiums ❒ Depreciation Holdback ❒ Replacement check ❒ Loss of use ❒ Other |
|  |  |

**I. POLICYHOLDER/CLAIMANT**

1. Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Physical Address: Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Suite No.: \_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

3. Mailing Address: Street/P.O. Box \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Suite No.: \_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_

4. Telephone No.: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**II. LEGAL REPRESENTATIVE**

1. Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Physical Address: Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Suite No.: \_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

3. Mailing Address: Street/P.O. Box \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt/Suite No.: \_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_

4. Telephone No.: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**III. Each Proof of Claim form should be accompanied by all supporting documents that are in the possession of the claimant. Supporting documents may include, but may not be limited to, policies, correspondence, bills, obligations, contracts, bonds complaints, judgments, estimates, photographs, damages, medical records, medical bills and/or evidence of out of pocket expenses, etc.**

(*List the enclosed documents):*

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

**IV. Claim is for:** *(Check all that apply)*

**Policyholders/Insureds:**

❒ Claim is made for a loss or occurrence arising under the coverage of the policy.

❒ Claim is made for the return of unearned premium due to early cancellation.

Was premium financed? ❒Yes ❒No

Amount of Premium/Consideration paid to date $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of Claim: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Claimants other than Policyholders/Insureds:**

❒ Claim is made against policyholder/Insured.

❒ Claim is made by an attorney for unpaid legal expenses.

❒ Claim is made by an agent or broker.

❒ Claim is made by a general creditor for unpaid invoices.

❒ All other claimants. (On a separate sheet, describe nature of claim and consideration given for it. Claim Amount $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.)

*Answer the following if applicable:*

No part of the debt has been paid except: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

There are no setoffs or counterclaims to the debt, except::\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

There is no Security for the debt, except:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Status of Claim:*

❒ Claim is based on a court judgment or settlement (attach order or agreement).

❒ Claim is currently pending in court (provide details and documents).

❒ Claim is not yet filed in court.

The Ancillary Receiver’s acceptance of the Proof of Claim form is not intended to nor does it constitute any waiver or relinquishment by the Receiver of any defense, setoff or counterclaim that he/she may have against any person, entity or governmental agency.

The undersigned subscribes and affirms as true, under penalty of perjury, under the laws of the United States Virgin Islands, the following:

1. That he/she has read the foregoing Proof of Claim form and knows the contents thereof.
2. That this claim is justly owing to the claimant.
3. That the matters set forth above and in any accompanying documents are true to the best of his/her knowledge and belief.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Claimant or

Authorized Representative

The foregoing instrument was Subscribed and Sworn before me this \_\_\_\_\_\_\_\_\_\_\_ day of\_\_\_\_\_\_\_\_\_\_\_\_\_, 2019 by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, whom I attest to know personally or identified with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTARY PUBLIC