PLEASE READ THIS FORM AND INSTRUCTIONS AND NOTE THAT YOU ARE MAKING THE FOLLOWING STATEMENTS UNDER OATH.

PROOF OF CLAIM

AGAINST

- **HRC MEDICAL CENTERS, INC.**
- **HRC MANAGEMENT MIDWEST, LLC**
- **DAN E. HALE, D.O.**
- **DON HALE**
- **BONNIE HALE**
- **DIXIE HALE**
- **SOUTHERN BELLE CONSULTING, LLC**
- **HRC MEDICAL CENTERS HOLDINGS, LLC**
- **HRC MANAGEMENT, LLC**
- **DANA HELTON, in her capacity as Trustee of the CARDINAL REVOCABLE TRUST**
- **LEGACY MEDICAL CENTERS, LLC**
- **BIOLIFECYCLE MEDICAL CENTERS, LLC**

(For Receiver's Use Only)

Claim # __________

Date Rec'd __________

1. **Claimant name**

____

2. **Claimant address**

____

Street **City** **State** **Zip Code**

3. **Contact name** ___________________________________

4. **Contact e-mail address** ____________________________

5. **Contact phone number** (_____) ________-____________

6. **Claimant Federal Tax ID** (Business Only)________________

7. **Employee Claimant last 4 digits of SSN** ______________

CLAIM INFORMATION

8. **Type of claim** (check applicable box)

☐ **Customer/patient** ☐ **Vendor** ☐ **Employee** ☐ **Other (explain)** ______________________________________

9. **If customer/patient**, dates of service: from ________ to ________. Service location: ______________________________

10. **If Vendor,** dates of service: from __________ to __________. Service location: ____________________________________

Description of services or product provided: ____

11. **If Employee,** the employer name: _________________________. Location of employment: _____________________________.

Job Title: ____. Date of the obligation___________________________________.

12. CUSTOMERS/PATIENTS, VENDORS AND OTHER(S) MUST ATTACH DOCUMENTS AND EXPLANATION OF WHY PROOF OF CLAIM IS BEING SUBMITTED. A CLAIM WILL NOT BE CONSIDERED WITHOUT THIS SUPPORTING DOCUMENTATION.

13. ANY EMPLOYEES THAT HAVE ANY OUT-OF-POCKET EXPENSE THAT HAS NOT BEEN REIMBURSED MUST ATTACH PROOF.

14. **Dollar amount of claim $**_______________________

15. **Number of pages, including this page** ____________

I declare that this claim is TRUE & CORRECT to the best of my knowledge and belief.

16. **Authorized signer name** (Please print) ____

17. **Authorized signer signature** ____

MAIL COMPLETED CLAIM FORM TO:

CLAIMS
HRC Receivership
P. O. Box 158249
Nashville, TN 37215

Inquiries concerning the Proof of Claim or the status of the liquidation may be directed to claims@hrcreceivership.com