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)

   D **Customer/patient** D **Vendor** D **Employee** D **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
2000 Richard Jones Rd., Ste. 250
Nashville, TN 37215

Inquiries concerning the Proof of Claim or the status of the liquidation may be directed to **jmclemore@gmylaw.com**