IMPORTANT LEGAL NOTICE

MAIL THE COMPLETED AND SIGNED FORM AND ALL OF YOUR DOCUMENTATION TO:
UNIVERSAL HMO OF TEXAS INC. IN RECEIVERSHIP
JEAN G. JOHNSON, SPECIAL DEPUTY RECEIVER
3767 Forest Lane, #124-425, Dallas, Texas 75244
Contact Number: (888) 907-1212
universaltxsdr@aol.com
For more information that impacts your legal rights go to www.universalhmotexasreceiver.com
THIS PROOF OF CLAIM FORM MUST BE SIGNED AND POSTMARKED OR DELIVERED NO LATER THAN 11:59PM CENTRAL TIME on JUNE 30, 2014. TO BE CONSIDERED TIMELY FILED

NOTICE TO CLAIMANTS AND PARTIES IN INTEREST OF THE UNIVERSAL HMO OF TEXAS INC. RECEIVERSHIP

RE: *The State of Texas v. Universal HMO of Texas, Inc.*; Cause No. D-1-GV-13-000384; In the 345th Judicial District Court of Travis County, Texas; Receivership No. 555
("the receivership proceeding")

On May 17, 2013, Universal HMO of Texas, Inc. **("Universal-TX")** was placed in receivership for the purposes of liquidation by order **("Liquidation Order")** of the 345th Judicial District Court of Travis County, Texas **("receivership court")**. The Texas Commissioner of Insurance is the Receiver of Universal-TX and has designated Jean G. Johnson as Special Deputy Receiver **("SDR")**.

Effect on Members and Beneficiaries:
Before the Liquidation Order, Universal-TX agreed with the Centers for Medicare & Medicaid Services **("CMS")** to terminate Universal-TX's Medicare Advantage contract, effective May 1, 2013. As a result, at 12:01a.m., Wednesday, May 1, 2013, Universal-TX plans terminated and members were given the option to be enrolled in Original Medicare or to receive benefits through a different company.

Effective May 1, 2013, Universal-TX members transitioned from Universal-TX to Original Medicare, or to alternate coverage. Texas members were enrolled in Cigna PDP for prescription drug coverage. At no point did Universal-TX members experience a gap in drug or health care coverage. Members may call 1-800-MEDICARE (1-800-633-4227), (TTY) 1-877-486-2048 or view www.medicare.gov for assistance identifying their prescription drug plan or Medicare benefits. Any beneficiary with questions about their Prescription Drug Coverage through Cigna should call 1-800-222-6700, (TTY) 1-800-322-1451.

Claim Filing Information:
All claims against Universal-TX will be handled as claims against the Universal-TX receivership estate, and all proceedings are governed by Texas Insurance Code Chapter 443. All claims (or any portion of a claim) against Universal-TX arising before May 1, 2013, must be made by a written proof of claim **("POC")**. The POC form is available on the SDR's website located at **www.universalhmotexasreceiver.com ("SDR website")**.

The receivership court has set a **CLAIMS FILING DEADLINE of 11:59 p.m., Central Time, on June 30, 2014 ("claims filing deadline")**. In order for a POC to be considered timely filed, it must be postmarked or delivered to the SDR before the claims filing deadline. Failure to complete the POC form according to the instructions may cause your claim to be delayed or disallowed. The SDR website has a **Frequently Asked Questions** section which contains additional information about filing POCs with the SDR.

There is an injunction preventing new lawsuits and staying existing lawsuits against Universal-TX under Texas Insurance Code § 443.008. The Liquidation Order prohibits medical providers from charging, billing, or collecting payment from members, enrollees, or beneficiaries of Universal-TX, or violating any applicable statutory or

contractual provisions. Medical providers will be required to verify that they have not violated this injunction and applicable statutory and contractual provisions when filing their proof(s) of claim for payment from the Universal-TX receivership estate.

The SDR specifically requests that all agents and reinsurance brokers send notice to the SDR of the name and address of all members and beneficiaries, certificate holders, and reinsurers contained in their files whose rights may be impacted by the Liquidation Order, the claims filing deadline, or the stay.

Procedures before the receivership court are contained in the *Order of Reference to Master*. Notice of matters filed in the receivership, and all hearings and status conferences will be posted on the SDR website. You may request to be added to the service list to receive all pleadings filed and notices of future status conferences in the receivership proceeding by emailing Kristin Lawrence at Kristin@wnglaw.com. If you request to be added to the service list on behalf of a specific company, please include both the company name and your name, address, phone number, fax number, and email address. If you are an attorney, please designate your client. The Special Master has set the next status conference for Monday, October 28, 2013 at 10:45 a.m. in Room 100 at 333 Guadalupe Street in Austin, Texas 78701.

Jean G. Johnson
Special Deputy Receiver of
Universal HMO of Texas Inc.
3767 Forest Lane, #124-425
Dallas, TX 75244

IMPORTANT LEGAL NOTICE

READ CAREFULLY BEFORE COMPLETING THE PROOF OF CLAIM FORM

INSTRUCTIONS#

Use this Proof of Claim form **("POC")** to make your claim against the receivership estate of Universal HMO of Texas, Inc. **("Universal-TX")**. By accurately completing this form you make your claim for payment, help the Special Deputy Receiver **("SDR")** identify your claim and allow the SDR the opportunity to properly consider your claim***. It is very important that you complete all the sections applicable to you, sign, and return the form to the SDR as provided below.*** The SDR will review your claim and decide according to receivership guidelines whether you are entitled to any amount of payment on your claim,

THE PROOF OF CLAIM FORM MUST BE SIGNED AND POSTMARKED NO LATER THAN 11:59 PM CENTRAL TIME ON JUNE 30, 2014, IN ORDER FOR YOUR CLAIM TO BE CONSIDERED TIMELY FILED. FAILURE TO TIMELY FILE YOUR PROOF OF CLAIM FORM WILL CAUSE YOUR CLAIM TO CLASSIFIED AS LATE AND POSSIBLY MADE INELIGIBLE FOR A DISTRIBUTION OF ASSETS, IF ANY.

To complete this form, please follow these instructions and all information concerning filing claims located in the Frequently Asked Questions section at www.universalhmotexasreceiver.com:

1. Provide your full name, permanent address, phone number, and (if you have computer access) your e-mail address. The Claimant can be the name of the Member, Provider of any Medical Services, Business Contacts, or Vendors of Services. During the course of the receivership, you must notify the SDR in writing of any mailing address and telephone number change. Failure to provide the SDR with any change in your address may delay review of your claim or may result in the disallowance or reduction of your payment if the claim is approved and assets are available.

2. The Claimant's Name and Social Security Number (or Tax ID number) are for the person incurring the expense or owed money by Universal-TX. You must provide the SDR your Social Security Number or Tax ID number, sign and date the POC. Claims filed by business organizations must be signed by an authorized representative, stating the capacity of the signatory. If an attorney is signing this form on behalf of a client, a power of attorney must be attached.

3. If you are a **Provider,** take special note of the additional information needed e.g. your EIN and your NPI number. Claims from Providers must include completed UB04 or CMS-1500 forms.

4. If you are a **Member** filing your own claims, please know all bills must be itemized showing dates of service and type of service rendered. "Balance forward statements" are not acceptable. If you have previously assigned your claim to a medical provider, please provide the SDR a copy of the assignment.

5. Indicate the type of claim and amount, if known, by checking the appropriate category and indicating the amount. If the amount of a claim is unknown, insert the word "unknown" in the amount column.

6. **YOU MUST INCLUDE DOCUMENTATION SUPPORTING YOUR CLAIM.** If you fail to adequately describe or document your claim, your claim may be disallowed.

7. If you are submitting a claim previously processed and you would like it to be considered as an appeal, please attach all supporting documentation and mark the claim(s) as an appeal.

8. To reduce expenses to the receivership estate, the SDR will not be sending acknowledgement of receipt of the Proof of Claim forms. You will, however, receive notice of any decision on your claim at the address you have provided to the SDR on the Proof of Claim form.

9. You must disclose all deposits, cash, premiums, securities, trust funds, letters of credit, or other assets of Universal-TX you hold or control. If you were an agent, please submit an accounting of all commissions held at the time plans were terminated.

10. After you complete the POC form, review the completed form, sign, and date it. Failure to properly complete the POC form according to these instructions may cause your claim to be delayed or disallowed.

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PROOF OF CLAIM
UNIVERSAL HMO OF TEXAS, Inc., IN RECEIVERSHIP

Claim Filing Deadline is 11:59 p.m. Central Time June 30, 2014

Claimant (Please Print)

Name: _____

Claimant Type:_____
(Member, Provider, other)

Birth Date: _____ **SSN:** _____

UHC ID No. _____ **Plan No.** _____

Provider: _____

NPI No. _____ **Tax ID No.** _____

Address: _____

_____

_____
(City) (State) (Zip)

Phone: _____ **Alt. Phone** _____

Email: _____

Provide the SDR with contact information of someone always able to contact you:

Name: _____

Address: _____

_____

_____
(City) (State) (Zip)

Phone: _____ **Alt. Phone** _____

Email: _____

IF A LAWYER REPRESENTS YOU, PLEASE ANSWER:

Attorney Name: _____

Law Firm Name: _____

Address: _____

_____

_____
(City) (State) (Zip)

Phone: _____ **Alt. Phone** _____

Email: _____

IF YOU ARE AN ATTORNEY COMPLETING THIS CLAIM YOU MUST ATTACH A NOTARIZED POWER OF ATTORNEY

Check the appropriate box below:

Claim for benefits under a health care plan issued by Universal HMO of Texas, Inc.		**Claim Amount:**
☐	**Provider Unpaid claims** [Line of Business: Medicare Advantage ☐ Other ☐]	**$**
☐	**Member Unpaid claims** (if enrolled in Universal HMO of Texas, Inc.)	**$**
Other Claims against Universal HMO of Texas, Inc.		
☐	Unpaid fees to vendors for goods and services	**$**
☐	Amounts due a governmental entity (City☐ County☐ State☐Federal☐)	**$**
☐	Other claim	**$**
TOTAL AMOUNT OF CLAIM (If the amount is unknown state "UNKNOWN"		**$**

Describe the nature of your claim: _____

_____

_____

If you have received an assignment of benefits, provide assignor's name and address below and attach copy of the assignment:
_____
_____

If you have assigned any part of your right of recovery, including assignment by medical providers to collections, provide assignee's name and address below and attach copy of the assignment:
_____

If you hold or exercise any control over any cash, securities, trust funds, letters of credit or other assets of Universal-TX , provide description and location of asset: _____
_____

Have you paid or settled any part of this claim? Please describe and attach supporting documentation: _____
_____

If you received any payments on your claim, provide the name of who paid you and the amount of payment:
_____

Is there any other insurance available to cover your claim? Yes _____No _____ If the Answer is "yes", what is the name, address, and phone number of the insurance company? Also, what is the policy number and name of the insured person?
_____
_____

YOU MUST ATTACH DOCUMENTATION TO SUPPORT THE CLAIM

Affirmation

I _____, (Check one) _____ as the Claimant, **or** _____ on behalf of the Claimant, affirm that I have read the Proof of Claim Form above and understand its contents, that the claim of $_____ against Universal-TX is justly owed to the Claimant. I have allowed all offsets, credits and payments in asserting the amount due in this proof of claim. I have not assigned to anyone this proof of claim or any portion of the liability asserted in this proof of claim.

I am authorized to sign on behalf of the Claimant set forth above, and I hereby verify that the foregoing facts are true and correct. By signing this Proof of Claim form, I understand and acknowledge that all or some of the information on this form will be used in approving the Proof of Claim and obtaining court approval of proposed payment. I hereby authorize the SDR, her representatives or agents to disclose, discuss, and/or release, orally or in writing, information contained in this Proof of Claim form. I agree to cooperate in signing additional release forms, if any, to authorize the SDR to act on this Proof of Claim.

I understand that I hereby assign to the SDR any rights I may have arising out of my claim against Universal-TX.

___ [For claimants who are providers or are otherwise not members of Universal-TX:] I hereby certify that I have not collected from the HMO member or health plan participant any portion of the sums upon which my Proof of Claim is based. I further certify that I will not seek to collect any further sums from Universal member or health plan participant arising from the Medicare Advantage plan offered by Universal.

_____ _____ _____
Date Signed Signature of Person Making Claim Printed Name

If someone other than the Claimant or their Attorney has completed this form, please provide the following information:

Name: _____ Relationship to Claimant: _____

Phone No. _____ Email: _____

Address: _____

Signature of Person Completing the Form _____

NOTICE - Return the completed form and all documentation supporting your claim to:

UNIVERSAL HMO OF TEXAS, IN RECEIVERSIHP
3767 Forest Lane No. 124-425
Dallas, Texas 75244

To ensure this claim is timely filed, the signed claim form and all supporting documentation must be delivered or postmarked with proper postage NO LATER THAN 11:59 P.M. CENTRAL TIME, ON JUNE 30, 2014.

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