

SOUTHEASTERN U.S. INSURANCE INC., IN LIQUIDATION

PROOF OF CLAIM NO. \_\_\_\_\_  
DATE RECEIVED: \_\_\_\_\_  
(For Internal Use Only)

READ ALL MATERIALS CAREFULLY BEFORE  
COMPLETING THIS FORM - COMPLETE ALL SECTIONS  
- FILL IN ALL BLANKS - PLEASE PRINT CAREFULLY  
OR TYPE

Name of claimant  
  
Address of claimant

If applicable, name of Southeastern U.S. Insurance Inc. policyholder and policy number.

Policyholder Name:  
Policy Number:

This claim is for:

- Loss under policy (Claim by insured of Southeastern for policy benefits)
- Unearned premium refund (Portion of paid premium not earned due or retro or audit adjustment)
- General Creditor (Attorney fees, Adjuster fees, Vendors, Landlords, Lessors, Consultants, Cedants, & Reinsurers)
- All Other (Describe)

In the space below give a concise statement of facts giving rise to your claim:

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

AMOUNT OF CLAIM: \$ \_\_\_\_\_

ATTACH COPIES OF ANY SUPPORTING DOCUMENTS SUCH AS CORRESPONDENCE, LAWSUITS, JUDGEMENTS, PREMIUM RECEIPTS, CANCELED CHECKS, ETC.

State of \_\_\_\_\_ County of \_\_\_\_\_

I HEREBY SWEAR OR AFFIRM UNDER PENALTY OR PERJURY THAT, TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE STATEMENTS AND ATTACHED SUPPORTING DOCUMENTS IN THIS CLAIM ARE TRUE AND CORRECT.

X \_\_\_\_\_  
Claimant's Signature Date

\_\_\_\_\_ Notary Public

My Commission Expires: \_\_\_\_\_

**NOTICE: ALL CLAIMS MUST BE RECEIVED BY THE LIQUIDATOR AT THE FOLLOWING ADDRESS ON OR BEFORE 4/26/2010 , OR BE FOREVER BARRED.**

SOUTHEASTERN U.S. INSURANCE INC., IN LIQUIDATION  
P.O. Box 1790  
Lilburn, GA 30048-1790  
PHONE (404) 869-6000