

PLEASE READ THIS FORM CAREFULLY AND NOTE THAT YOU ARE MAKING THE FOLLOWING STATEMENTS UNDER OATH:

PROOF OF CLAIM

Against

Tennessee Restaurant Association Self Insured Workers' Compensation Trust (TRA-SIWCT)

Type of Claim (check one): Workers' compensation claim filed by EMPLOYEE Workers' compensation claim filed by EMPLOYER
 Vendor Provider Other (explain: _____)

Claimant Name _____
(Party who is executing this claim)

Claimant Address _____
(Street or Box Number) (City) (State) (Zip Code)

Work Phone () _____ - _____ Home Phone () _____ - _____ Contact Person _____

Insured Address _____
(Street or Box Number) (City) (State) (Zip Code)

WORKERS' COMPENSATION CLAIMS FILED BY EMPLOYEE OR EMPLOYER: (Submit 1 claim per proof of claim form.)

Employee Name: _____ Date of Loss: _____ Time Lost from Job: _____

Claim No: _____ State of Residence When Claim Occurred: _____ Date Released from Medical Care: _____

Temporary Partial Disability Claimed: \$ _____ Temporary Total Disability Claimed: \$ _____

Permanent Partial Disability Claimed: \$ _____ Permanent Total Disability Claimed: \$ _____

Future Medicals Claimed: \$ _____ Death Benefit Claimed: \$ _____ Other: \$ _____

If an amount is listed as "other", state basis of your claim. _____

Total Amount Claimed Due: \$ _____ (This must be completed)

Attach a description of the claim and list any amounts/benefits received to date. Attach an IRS W-9 Form, available at www.irs.gov.

Employers/Insureds: If you are an employer submitting this claim to assert insurance coverage for employees (or former employees), then for each employee for whom you submit a claim, you must provide the following in addition to the workers' compensation claim information above:

Employee: () _____ - _____
(Employee Phone Number) (Employee Current Street or Box Number) (City) (State) (Zip Code)

Employer/Insured Policy Number _____ Employer/Insured Federal Tax ID No. _____

CLAIMS FILED BY PROVIDERS: Attach claim documentation. Attach an Internal Revenue Service W-9 Form, available at www.irs.gov.

CLAIMS FILED BY VENDORS AND OTHERS: Amount Claimed: \$ _____

Attach a detailed description of the claim, including: (1) consideration given for the claim; (2) payments made on the claim; (3) security for the claim, if any, and the value of the security and right of priority of payment; and (4) any other pertinent information regarding the claim. If your claim is based upon a written document, attach a copy of the document. Attach an Internal Revenue Service W-9 Form, available at www.irs.gov.

Attorney's Name (if applicable): _____ Phone No: () _____ - _____

Attorney's Address: _____
(Street or Box Number) (City) (State) (Zip Code)

BEFORE ME, the undersigned Notary Public, appeared the person whose name is subscribed hereto, who states under oath the following: I hereby certify that the above account is TRUE and CORRECT and no part of the amount claimed has been paid by TRA-SIWCT and that there is no setoff, counterclaim or defense to this claim.

State of _____ County of _____
Sworn to or affirmed before me this ____ day of _____ 2006.

Notary
My Commission Expires: _____

(Claimant's Signature)
If claimant is a Corporation, Partnership or
Limited Liability Company, state your Title or Position
Title: _____

THE CHANCERY COURT OF DAVIDSON COUNTY ESTABLISHED A DEADLINE THAT ALL FULLY COMPLETED PROOFS OF CLAIMS MUST BE RECEIVED BY THE LIQUIDATOR ON OR BEFORE
June 30, 2006, At 4:30 P.M. Central Time

Mail Proof of Claim, IRS W-9 Form, and any attachments to: TRA-SIWCT IN LIQUIDATION P.O. BOX 680638 FRANKLIN, TN 37068	Hand Deliver Proof of Claim, IRS W-9 Form, and attachments to: CCMSI FOR TRA-SIWCT IN LIQUIDATION 750 Old Hickory Blvd, Building Two, Suite 100 Brentwood, TN 37027
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