(To Be Completed by SDR)

DATE RECEIVED: ______________
(To Be Completed by SDR)

PROOF OF CLAIM

THE DEADLINE FOR FILING YOUR PROOF OF CLAIM IS 11:59P.M. C.S.T., NOVEMBER 30, 2007

☐**VESTA FIRE INSURANCE CORPORATION IN RECEIVERSHIP**
☐**SHELBY CASUALTY INSURANCE COMPANY IN RECEIVERSHIP**
☐**THE SHELBY INSURANCE COMPANY IN RECEIVERSHIP**
☐**TEXAS SELECT LLOYDS INSURANCE COMPANY IN RECEIVERSHIP**
☐**SELECT INSURANCE SERVICES, INC. IN RECEIVERSHIP**
(Collectively referred to as the "Vesta Receiverships")

PLEASE PRINT

Claimant's Name: ______________________________

Street Address: ______________________________

____
City State Zip

Phone: ______________ Fax: ______________

E-Mail Address: ______________ DOB: ______________

Social Security No. or Tax ID No.: ______________

Provide us with the name, address and phone number of someone who will always know how to contact you:

Name: ______________________________

____
Address City State Zip

Phone Number: ______________ E-Mail: ______________

(If represented by an attorney, please complete this section)

Name of Attorney: ______________________________

Name of Law Firm: ______________________________

Attorney File No.: ______________________________

Street Address: ______________________________

____
City State Zip

E-Mail Address: ______________________________

Phone: ______________ Fax: ______________

Tax ID No.: ______________________________

POLICY NO. ______________

CLAIM NO. ______________

Note: Attach a Copy of Power of Attorney

You must notify us of any change in the above addresses or phone numbers.

Claim is for (check the appropriate box below): **Claim Amount:**

☐ Payments made or expenses incurred by a Guaranty Association in paying covered claims.......................................$________
☐ Claim, cost of defense, or expense under a policy of insurance not covered by a Guaranty Association ....$________
☐ Return of premium under a policy of insurance not covered by a Guaranty Association...$________
☐ Unpaid pre-receivership policy costs such as fees to attorney or other professional services.................................$________
☐ Unpaid fees for goods and services to vendors ....$________
☐ Unpaid commissions or invoices to agents or brokers...$________
☐ Reinsurance (Facultative ☐ Assumed ☐ Ceded ☐ Premium☐....check one)...$________
Broker:______________ Type of Business:______________ Underwriting Years:______________
☐ Insurance company claim for subrogation ☐ contributions☐ indemnity☐...$________
☐ Amounts due a governmental entity (city☐ county☐ state☐ Federal☐)..$________
☐ Other claim..$________

TOTAL AMOUNT OF CLAIM (If the amount is unknown insert the word unstated")... $________

Describe the nature of your claim: ______________________________

____

____

Date of loss: ______________ Residency at time of loss: ______________

If you have an assignment of benefits, provide assignors name and address below and attach copy of the assignment:

____

____

If you have assigned any part of your right of recovery, 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 the Vesta Receiverships provide description and location of asset: ______________________________

____

____

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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 of the insurance company? ______________________________
Contact Person: ______________________________ Phone No.: ______________________

NOTE: ATTACH DOCUMENTATION TO SUPPORT YOUR CLAIM

AFFIRMATION OF CLAIMANT

I, ______________________________ affirm that I have read the foregoing Proof of Claim and understand the contents thereof, that this claim of $____________ against the Vesta Receiverships is justly owing to me, that I alone am entitled to file this claim, except as stated above, that there is no setoff to the claim thereto, except as stated above, that the matters set forth above and any accompanying statements and documents are true to my own knowledge, and that no payment of or on account of the aforesaid claim has been made, except as stated.

By signing this Proof of Claim form claimant understands that all or some of the information on this form will be used in approving the Proof of Claim and obtaining court approval. Claimant hereby authorizes the Vesta Receiverships, its affiliates or representatives or agents to disclose, discuss, and/or release, orally or in writing, information contained in this Proof of Claim form. Claimant agrees to cooperate in signing additional release forms, if any.

CLAIMANT UNDERSTANDS THAT BY FILING THIS CLAIM IN THE ESTATE OF THE INSURER CLAIMANT IS WAIVING ANY RIGHT TO PURSUE THE PERSONAL ASSETS OF THE INSURED TO THE EXTENT THAT THERE ARE POLICY LIMITS OR COVERAGE PROVIDED BY THE VESTA RECEIVERSHIPS

______________________________ ______________________________
DATE SIGNED SIGNATURE OF PERSON MAKING CLAIM

______________________________ ______________________________
TITLE (IF APPLICABLE) PRINTED NAME

If someone other than the person making the claim has completed this form, please provide the following information:

Date: ______________________ Name: ______________________________

Address: ______________________________ Relationship to Claimant: ______________________

______________________________ ______________________________
Phone Number Signature of Person Completing the Form for the Claimant

IMPORTANT NOTICE

RETURN THE COMPLETED POC AND REQUESTED DOCUMENTATION TO:
VESTA RECEIVERSHIPS
P.O. Box 1133, DRIPPING SPRINGS, TEXAS 78620-1133
CONTACT NUMBER: 1-888-313-5685
www.sdrtxpoc.com
THE DEADLINE FOR FILING YOUR PROOF OF CLAIM IS 11:59P.M. C.S.T., NOVEMBER 30, 2007