If you have more than one claim, you must copy this form to report additional claims

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

PROOF OF CLAIM

Against

Murray Inc. Workers' Compensation Bond Fund In Receivership (MI-WCBF)

BEFORE ME, the undersigned Notary Public, appeared the person whose name is subscribed hereto, who states under oath that, Murray Inc. Workers' Compensation Bond Fund, after deducting all offsets and counterclaims is indebted to him/her as follows:

Claimant Name _____ Claim No: _____
(Party who is executing this claim and to whom payment should be made) (If Known)

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

Work Phone ( ) _____-_____ State of residence at the time the claim(s) occurred: _____
Home Phone ( ) _____-_____ Federal Tax ID No.: _____

Insured _____ Policy No.: _____

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

_____
(State particulars of your claim, including consideration given for the claim, and the payments made on your claim, if any.)
(Attach additional sheets of paper, if necessary.)

_____
(Identify the security for your claim and its value and any right to priority of payment.)

Have you received any amounts or benefits from MI-WCBF since October 24, 2005? _____ If yes, the Receiver requires confirmation that you desire those benefits and payments to be included as part of your proof of claim. **Please check here _____,** to confirm their inclusion in the Proof of Claim. **FAILURE TO CONFIRM THROUGH CHECKING THIS ITEM WILL ENTITLE THE RECEIVER OF MI-WCBF TO RECOVER THESE AMOUNTS FROM YOU.** All past and future payments are with reservation of rights. The Receiver does not admit ultimate liability for this payment or any future payments you may receive. Consequently, should the Receiver determine that the payment enclosed with this letter or any future payments are not properly payable, the Receiver may recover the funds.

Describe and list any amounts or benefits received to date:
_____

Attorney's Name: _____

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

Date of Loss: _____ Time Lost from Job: _____ Date Released from Medical Care: _____ Temporary Partial Disability Claimed $ _____ Temporary Total Disability Claimed $ _____
Future Medicals Claimed: $_____ Permanent Partial Disability Claimed: $_____ Permanent Total Disability Claimed: $_____ Death Benefit Claimed:$ _____Other: $_____ **Total Amount Claimed Due: $_____**
If an amount is listed as other, state basis of your claim. _____ **(This must be completed)**

I hereby certify that the above account is TRUE and CORRECT and no part of the amount claimed due has been paid by MI-WCBF. There is no setoff, counterclaim or defense to this claim. If your claim is based on a written document, please attach a copy of the document that is the basis of your claim.

State of _____ County of _____

Sworn to or affirmed before me this _____ day of _____ 2004.

My Commission Expires: _____ _____
Notary

_____
(Individual Claimant's Signature)

If claimant is a Corporation, Partnership or Limited Liability Company, state your Title or Position

Name of Organization: _____

By: _____

Title: _____

THE CHANCERY COURT OF DAVIDSON COUNTY HAS ESTABLISHED A DEADLINE THAT ALL FULLY COMPLETED PROOFS OF CLAIMS MUST BE RECEIVED BY THE RECEIVER ON OR BEFORE MARCH 1, 2006 AT 4:30 P.M. CDT AT THE FOLLOWING ADDRESS: MI-WCBF Receiver, Aundreas W. Smith, P.O. Box 281257, Nashville, TN 37228.