**COMPASS COOPERATIVE MUTUAL HEALTH NETWORK, INC. dba MERITUS MUTUAL HEALTH PARTNERS**
**COMPASS COOPERATIVE HEALTH PLAN, INC. dba MERITUS HEALTH PARTNERS**

**NOTICE OF RECEIVERSHIP AND CLAIMS FILING DEADLINE – May 15, 2017**

*State of Arizona, ex rel. Leslie R. Hess, Interim Director of Insurance vs. Compass Cooperative Mutual Health Network, Inc., dba Meritus Mutual Health Partners and Compass Cooperative Health Plan, Inc. dba Meritus Health Partners No. CV 2016-011872 in the Superior Court of Arizona, Maricopa County*

The State of Arizona has placed the above Companies ("Meritus Mutual" and "Meritus Health Partners") into receivership and ordered their liquidation. Leslie R. Hess, Interim Director of the Arizona Department of Insurance, has been appointed as the Receiver for the Companies.

**THE COURT HAS SET A CLAIMS FILING DEADLINE OF MAY 15, 2017.**
**All claims must be filed using the approved Proof of Claim Form and must be postmarked or presented on or before 11:59 p.m. on May 15, 2017 to the Receiver at the following address:**

Meritus, In Receivership
Attention: Proof of Claims
Raintree Corporate Center I
15333 North Pima Road, Suite 305
Scottsdale, AZ 85260

**ANYONE (EXCEPT PROVIDERS) MUST USE THE PROOF OF CLAIM FORM TO SUBMIT A CLAIM.**
Anyone that believes he or she has a claim against Meritus Mutual or Meritus Health Partners MUST file a Proof of Claim on the approved form in order to receive the Receiver's consideration for payment of the claim. This includes vendors, policyholders, members and insureds. You must file a Proof of Claim even if the amount of your claim is unknown.

**PROVIDERS ARE NOT REQUIRED TO USE THE PROOF OF CLAIM FORM TO SUBMIT A CLAIM**.
Instead, Providers with claims for health care services provided MUST submit the claim(s) to Meritus Mutual and/or Meritus Health Partners in the usual manner used in the normal course of business for processing and adjudicating claims. In addition: (1) the Receiver will communicate to each Provider a Notice of Claim amount determined in accordance with the Arizona Insurer Receivership Act; (2) if a Provider objects to the claim amount in the Notice, that Provider must file a written notice of objection with the Receiver within thirty (30) days after the date of the Notice; (3) the Receiver will file with the Court notice of the Provider's objection to the claim amount, along with the Receiver's recommendation; and (4) any such disputed claim will be resolved by the Receivership Court, subject to and in accordance with the Arizona Insurer Receivership Act. Providers whose claims have already been submitted to Meritus Mutual and/or Meritus Health Partners do not need to submit a duplicate claim and should not do so.

**Non-Provider**: please follow these instructions in completing the attached Proof of Claim Form.

1. Complete all information on the Proof of Claim form. You may attach documentation or additional pages.
2. Indicate the type of claim by checking the appropriate category. Fill in the dollar amount of your claim where indicated. If the amount of your claim is unknown, state "unknown" on the form. You must file a Proof of Claim even if the amount of your claim is unknown.
3. Vendors and agents for unpaid goods, services or commissions must include a copy of the original contract (or a detailed description of the agreement) as well as detailed invoices or reports documenting the basis and amount of the claim.
4. Use additional sheets as needed in order to describe your claim. Explain all calculations and include all documentation supporting your claim. If your claim is inadequately described or documented, the Receiver or this Court may disallow it.
5. Notify the Receiver of any change in your address or contact information that occurs after filing of your Proof of Claim.
6. Consult the Companies' website for information regarding the Receivership, available at: http://meritusaz.com/receivership-and-court-filings/. This web page includes information about filing a claim and about the receivership generally.
7. Claims received after May 15, 2017 will be untimely and ineligible for payment, unless the claimant can show good cause for not filing the claim or the Receiver finds it eligible within her discretion.
8. You must specify whether your claim is against Meritus Mutual or Meritus Health Partners as required on the Proof of Claim Form. Each Company has different assets, and under Arizona law, each company is subject to different systems for payment and for establishing the priority of claims.
9. Claims submitted via email or fax will not be accepted.

# PROOF OF CLAIM FORM

**MERITUS MUTUAL – MERITUS HEALTH PARTNERS**

Read the enclosed instruction sheet carefully before completing this form. Complete each section of the form and attach documentation. **All Proof of Claim Forms must be presented or postmarked to the Receiver at the specified address by the Claims Filing Deadline of 11:59 p.m. on May 15, 2017.**

**Address for Submitting Claims:** Meritus, In Receivership
Attention: Proof of Claims
Raintree Corporate Center I
15333 North Pima Road, Suite 305
Scottsdale, AZ 85260

PLEASE PRINT – ATTACH SUPPORTING INFORMATION AS NECESSARY

## SECTION ONE – Claimant Contact Information

| **Claimant Name & Address** | | |
|---|---|---|
| Full Legal Name: | | |
| Social Security or EIN Number: | | |
| Meritus Member ID #: | | Date of Birth: |
| Mailing Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |
| **Attorney Representation:** If Claimant is represented by an attorney, please direct all communication regarding this Proof of Claim to Claimant's attorney using the following contact information: | | |
| Attorney's Name: | | |
| Attorney's Mailing Address: | | |
| City: | State: | Zip: |
| Phone: | Fax: | Email: |

## SECTION TWO – Information Regarding Claim

**Company:** This claim is filed against: [check appropriate box(es) below]

[__] Compass Cooperative Health Plan, Inc. dba Meritus Health Partners (HMO)

[__] Compass Cooperative Mutual Health Network, Inc., dba Meritus Mutual Health Partners (PPO)

**Claim Type and Amount:** [check appropriate box(es) below and indicate amount]

[__] Policyholder, Insured or Member

[__] Shareholders/Owners

[__] Agent, Vendor or other Creditor for goods or services provided

[__] All other Claims

**Amount of Claim:** $_____

**Explanation of the Nature of the Claim**
Attach additional sheets for explanation as necessary. Identify Attached Documentation, if any:

| |
|---|
| |

**Security**
If you are asserting a secured claim or otherwise asserting rights to any security, you must complete this section:

[__] Yes. I am asserting a secured claim.

If so and you hold or exercise any control over the cash, securities, trust funds, letters of credit or other assets of Meritus Mutual or Meritus Health Partners, you must explain the nature of your control and provide supporting documentation.

_____
_____

## SECTION THREE – Affirmation of Claimant

I affirm: (i) that I have read the foregoing Proof of Claim and understand the contents thereof; (ii) that this claim is justly due and owing; (iii) that I am entitled to file this claim; (iv) that the matters set forth above and in any accompanying statements and documents are true and correct to my own knowledge; and (v) that no payment of or on account of the aforesaid claim has been made, except as otherwise stated in my claim.

**Signature of person (or authorized agent) making claims**

Signature: _____

Printed Name: _____

Title: (if applicable): _____

Date Signed: _____

**For Internal Office Use Only: POC # _____ Claim Type: _____ Postmarked Date: _____**