

PROOF OF POLICY CLAIM FORM

Date: _____

Financial Guaranty Insurance Company

463 Seventh Avenue

16th Floor

New York, New York 10018

Attention: Surveillance

Email: sfsurv@fgic.com

Facsimile: (212) 312-2774

Reference Policy Number: _____

Reference is made to (i) the order, dated June 11, 2013 (the “**Plan Approval Order**”) approving that certain First Amended Plan of Rehabilitation for Financial Guaranty Insurance Company (together with all exhibits and supplements thereto, as the same may be modified from time to time, the “**Plan**”), dated June 4, 2013, (ii) the attached claim schedule (the “**Claim Schedule**”), which includes detailed information about one or more claims (each a “**Claim**” and collectively, the “**Claims**”) made pursuant to this Proof of Policy Claim Form¹ and (iii) the Policy issued by Financial Guaranty Insurance Company (“**FGIC**”) (as modified by the Plan), which is identified above and on the Claim Schedule, and which insures the insured obligation identified on the Claim Schedule (the “**Insured Obligation**”).

The undersigned (on behalf of its principal, if the undersigned is acting as an agent for the Policyholder) hereby certifies, represents and warrants as follows:

1. The undersigned (or its principal, if the undersigned is acting as an agent for the Policyholder) is the Policyholder under the Policy and is entitled, under and in accordance with the terms and conditions of the Policy (as modified by the Plan) with respect to the Insured Obligation, to submit the Claims for the amount specified in the Claim Schedule. Neither the Policy, the Claims or any portion thereof or any right or interest therein, nor any claim, contention, demand, or cause of action relating to the Policy and/or any Claim or any portion of any recovery or settlement related thereto has been sold, granted, transferred, assigned or encumbered, including, without limitation, by subrogation, by operation of law, under contract or otherwise.
2. The “Total Claim Amount” set forth on the Claim Schedule with respect to the Insured Obligation (the “**Total Claim Amount**”) is due for payment pursuant to the terms of the Policy (as modified by the Plan) and the contracts and instruments relating to or governing the Insured Obligation.

¹ Capitalized terms not defined herein have the meanings ascribed to them in the Plan.

3. The undersigned has not from and after the Effective Date made a claim or demand for payment under the Policy in respect of amounts due on the Insured Obligation, except as otherwise specified in an addendum to this Proof of Policy Claim Form submitted by the Policyholder herewith.

Check the box below if the undersigned is attaching an addendum to this Proof of Policy Claim Form listing any previously submitted Claims under the Policy:

The undersigned hereby agrees that the list of previously submitted Claims identified in the addendum to this Proof of Claim Form does not constitute a new Claim and is being included for informational purposes only.

4. As of the date of this Proof of Policy Claim Form, no FGIC Payments are owed to FGIC by the undersigned with respect to the Policy that have not been paid to FGIC other than the following FGIC Payments:

Amount: \$ _____
Description: _____

5. The undersigned has duly completed and submitted to FGIC any document(s) and information required to be submitted by the Policy in the form specified by the Policy.

Check the box below if the undersigned is attaching any such documents or other information:

The undersigned hereby confirms that all conditions to the receipt of the Total Claim Amount, including the completion and submission of any required document(s) and information, have been satisfied, and the aggregate amount claimed in any such document(s) is equal to the Total Claim Amount.

The undersigned hereby requests that the portion of the Total Claim Amount to be paid by FGIC in Cash be made to the following account by bank wire transfer or other immediately available funds:

Currency: _____
Correspondent Bank: _____
Fed ABA No: _____
Correspondent SWIFT: _____
Beneficiary A/C No: _____
Beneficiary A/C Name: _____
Reference: _____

Check this box if the wire transfer instructions have changed from those previously submitted to FGIC.

The following two (2) officers or employees of the Policyholder are authorized to receive communications and provide additional information concerning the Claims:

1. Name _____
Address _____

Phone number _____
E-mail _____

2. Name _____
Address _____

Phone number _____
E-mail _____

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD FGIC OR ANOTHER PERSON FILES A PROOF OF POLICY CLAIM FORM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS ANY INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT ACT WHICH MAY BE SUBJECT TO CIVIL AND/OR CRIMINAL PENALTY.

If executed by the Policyholder:

As Policyholder

By: _____

Name:

Title:

If executed by an Agent for the Policyholder:

As Policyholder

By: _____

As Agent for the Policyholder

By: _____

Name:

Title:

CLAIM SCHEDULE**DATE:** _____

Policy Number: ¹		Policyholder:				
Issuer:						
Contact 1 Name: ²		Contact 1 Firm Name:				
Contact 1 Phone:		Contact 1 eMail:				
Contact 2 Name:		Contact 2 Firm Name:				
Contact 2 Phone:		Contact 2 eMail:				
Title of Insured Obligation (name of bond/other):					Short Name:	
Distribution Date: ³	Claim Period: ⁴ (Start Date - End Date)	Principal Amount Due On Insured Obligation on Distribution Date	Interest Amount Due on Insured Obligation on Distribution Date	Pre-Commencement Date Interest On Unpaid Claim	Other Amount	Total Claim Amount
	-					
	-					
	-					
	-					
	-					

¹ Please use a separate Proof of Policy Claim and Claim Schedule for the Claims arising under each separate Policy. Claims relating to more than one class of bonds or certificates that are all insured under the same Policy should all be included in a single Claim Schedule. Claims that are in the same class of bonds or certificates that are all insured under the same Policy, but have multiple Distribution Dates should also all be included in a single Claim Schedule.

² Please supply the contact information for two (2) officers or employees of the Policyholder who are authorized to receive communications and provide additional information concerning the Claims.

³ "Distribution Date" is the date on which principal and/or interest is due for payment with respect to the Insured Obligation as provided by the indenture, servicing agreement or other operative document. If Claims arose from amounts payable on more than five Distribution Dates, append an extended Claim Schedule spreadsheet in the same format.

⁴ The "Claim Period" is the period in respect of which payments are due on the stated Distribution Date as provided by the indenture, servicing agreement or other operative document.