INSTRUCTIONS FOR PROOF OF CLAIM AGAINST
OPTICARE OF UTAH INC., IN LIQUIDATION

Please follow these instructions carefully.

- Medical Providers ARE NOT required to file a Proof of Claim.
- The claim form must be filled out as accurately as possible. Forms that are incomplete or inaccurate may result in a delay or denial of your claim.
- Attach additional sheets to the form if more space is needed.
- If the category of your claim is not included in the list on the form, check “other” and identify the nature of the claim with sufficient clarity to allow for classification.
- Attach any contract, invoice, undertaking or other evidence to support your claim.
- If you are filing electronically, it is not necessary to mail this form. However, if you are mailing this form, you must print the form and mail or deliver to the address below. If mailed, the postmark must be by 5:00 P.M. Mountain Daylight Time on the bar date. If delivered it must be received at the address below by 5:00 P.M. Mountain Daylight Time on the bar date.
- It is the Claimant's responsibility to inform the Liquidator of any changes to the Claimant's name, EIN, email address, telephone number, or address once a Proof of Claim is submitted.

THE BAR DATE IS MARCH 31, 2025 AT 5:00 P.M. MOUNTAIN DAYLIGHT TIME.

Claims received after the bar date may be barred or receive a reduced distribution.

Please return electronically to: info@utreceivers.com

If not filed electronically, Proof of Claim forms must be sent or delivered to the following address:

Opticare of Utah Inc., in Liquidation
Utah Receiver’s Office
250 East 200 South Suite 1250
Salt Lake City, UT 84111

PROOF OF CLAIM AGAINST
OPTICARE OF UTAH, INC., IN LIQUIDATION

READ THIS INSTRUCTION SHEET CAREFULLY

LAST DAY TO FILE A PROOF OF CLAIM IS MARCH 31, 2025, AT 5:00 P.M. MOUNTAIN DAYLIGHT TIME

Attach Documentation to Support Your Claim

Claimant Type	Claim Amount
_____ Member	_____
_____ Broker	_____
_____ Vendor	_____
_____ Other (Describe in Detail)	_____
Total	_____

The Particulars of the Claim (dates, nature, etc.) and the consideration (amount given) for the claim (attach an additional sheet if needed). If the claim has been assigned, so state:

_____

_____

_____

Identity and Amount of Security for the Claim, if any:

_____

_____

Identity and Payments Made Against the Debt:

_____

_____

Claimant Name (PRINT)

_____
Name

_____
Address

_____
City, State and Zip

_____
Telephone

_____
Email Address

Attorney (IF ANY)

_____
Name

_____
Address

_____
City, State and Zip

_____
Telephone

_____
Email Address

T**he undersigned affirms that the claim is justly owing and there is no setoff, counterclaim or defense.**

_____ _____ _____

Signature of Claimant or Attorney | SSN or Tax I.D. | Date