

**RELEASE AND WAIVER AGREEMENT (the “Release”) FOR SPIRIT COMMERCIAL AUTO
RISK RETENTION GROUP, INC. (“SPIRIT”) IN LIQUIDATION**

Proof of Claim (“POC”) Number: SP-_____

POC Claimant Name: _____ (hereinafter below, the “Releasor”)

Spirit Claim # _____ (hereinafter below, the “Spirit Claim”)

Total Allowed Amount: _____ (hereinafter below, the “TAA”)

Initial Distribution Amount: _____ (hereinafter below, the “IDA”)

1. Release. In exchange for the IDA, Releasor fully releases and discharges Spirit, its Receiver, and Special Deputy Receiver (SDR), and all related persons and entities (the “Releasees”) from any and all claims—known or unknown—arising from the Spirit Claim.

2. Payment. The IDA will be paid by Releasees upon execution and compliance with this Release.

3. Waiver. Releasor waives all claims against Spirit’s insured up to the IDA, and agrees to credit and disclose any payments received from a Spirit insured or other third party. This waiver also applies to future distributions, if any. Releasor will credit the Spirit insured for any distribution payments collected from the Receiver.

4. No Admission. Payment of the IDA or any later distribution is not an admission of liability and settles disputed claims only.

5. Future Distributions. Releasor understands the IDA represents about 20% of the allowed claim. Any additional payments require Receivership Court approval and are not guaranteed or promised.

6. Assignment. Releasor assigns to Spirit all claims or rights against Spirit’s affiliates or defendants in the Receiver’s asset recovery actions (*i.e.*, whether in state, federal, or bankruptcy court) related to the TAA but retains the right to any future distributions on the unpaid balance.

7. Indemnification. Releasor indemnifies and holds Releasees harmless from all liens, claims, or demands for the IDA, including any by the Centers for Medicare and Medicaid Services (“CMS”), and is solely responsible for all CMS notification, reimbursement, and recovery obligations.

8. Taxes. Releasor has provided a valid IRS W-9, is responsible for any taxes due, and certifies the accuracy of tax and payee information provided in the W-9.

9. CMS Reporting & Cooperation. Releasor will provide complete and accurate Medicare/Medicaid reporting data and continue to cooperate with the Receiver. Failure to do so may result in loss of payment eligibility.

10. Governing Law. This Release is governed by Nevada law, and any action shall be brought in the Spirit Receivership Court, Clark County, Nevada.

11. Entire Agreement. This document constitutes the full agreement. Releasor affirms being over eighteen, competent, acting voluntarily, and not relying on any statements outside this Release.

Signature

Releasor must sign before a Notary Public. By signing below, Releasor agrees to this Release.

Releasor Signature

Releasor Printed Name

State of _____ §

County of _____ §

Subscribed and sworn before me this ____ day of _____ 20____.

NOTARY PUBLIC

[Notarial Seal/Stamp]

(Printed Name of Notary)

Spirit Commercial Auto Risk Retention Group, Inc., in Receivership for Liquidation

Class B Claim Distribution Payment Instruction Form

Claim Information

Proof of Claim (“POC”) Number: _____
POC Claimant Name: _____
Total Allowed Amount: _____
Initial Distribution Amount (“IDA”) _____

Payment Instructions

- Make IDA check payable to the POC Claimant Name as written above.
- Make IDA check payable to the following individual/entity on behalf of the POC Claimant:

(e.g., check will be made payable to “ABC Law Firm, LLC, o/b/o Jane Doe claimant”)

* If neither of the above options apply to your distribution payment (e.g., if payment will be made to a successor-in-interest, assignee, or heir of the POC Claimant), please call (512) 478-6000 to request the appropriate forms.

Mailing Instructions

Please provide the address where the check should be mailed:

Name/Attention: _____

Street Address: _____

City, State, Zip: _____

Lien or Assignment Disclosure

POC Claimants are responsible for resolving any liens or assignments which may apply to their claim payments, and must indemnify and hold the Receiver harmless for any third-party demands for payment of the claim distribution payments.

Class B Claim Distribution Payment Instruction Form

Spirit Commercial Auto Risk Retention Group, Inc., in Receivership for Liquidation

CMS Data Collection Form

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other insurance in addition to their Medicare benefits. Sometimes, Medicare is supposed to pay after the other insurance. However, if certain other insurance delays payment, Medicare may make a “conditional payment” so as not to inconvenience the beneficiary and recover after the other insurance pays.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a federal law that became effective January 1, 2009, requires that liability insurers (including self-insurers), no-fault insurers, and workers’ compensation plans report specific information about Medicare beneficiaries who have other insurance coverage. The Receiver for Spirit Commercial Auto Risk Retention Group, Inc. (“Spirit”) is asking you to answer the questions below so that the estate may comply with this law.

Please review this picture of the Medicare card to determine if you have, or have ever had, a similar Medicare card.

Please note the Medicare Number located on this card.



Are you presently, or have you ever been, enrolled in Medicare? **Yes** **No**

Full Name: (please print first, middle, and last name exactly as it appears on your SSN or Medicare card if available)

Medicare Number

(if available)

Social Security Number (if

Medicare No. unavailable)

Date of Birth

(Month/Day/Year)

Sex

Female Male

Spirit Commercial Auto Risk Retention Group, Inc., in Receivership for Liquidation

I understand that the information requested is to assist the Spirit receivership in meeting its mandatory reporting obligations under Medicare law.

Claimant Name

(Please Print)

Proof of Claim Number

**Name of Person
Completing This Form if
Claimant is Unable**

(Please Print)

**Signature of Person
Completing This Form**

Date *(Month/Day/Year)*

If you have completed the above sections, stop here. If you are refusing to provide the information requested above, proceed to the section below.

Claimant Name

(Please Print)

Proof of Claim Number

I understand that if I am a Medicare beneficiary and I do not provide the requested information, I may be violating obligations as a beneficiary to assist Medicare in coordinating benefits to pay my claims correctly and promptly.

I also understand that if any claimant fails or refuses to cooperate with any request for data needed to meet CMS or other legal reporting requirements, the Receiver has grounds to withhold distribution of payment for that claim.

**Reason(s) for Refusal
to Provide Requested
Information**

**Signature of Person
Completing This Form**

Date *(Month/Day/Year)*
