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 "Minor Child")
Spirit Claim # _____ (hereinafter below, the "Spirit Claim")
Total Allowed Amount: _____ (hereinafter below, the "TAA")
Initial Distribution Amount: _____ (hereinafter below, the "IDA")

We, _____ and _____(names), are the parents or legal guardians of the above-referenced Minor Child, and are making this Release on behalf of ourselves and the Minor Child (hereinafter below, the "Releasors"), and hereby warrant and agree that we have legal authority to make this Release on behalf of the Minor Child and that we shall have exclusive responsibility for ensuring compliance with any applicable laws, including but not limited to state statutes and probate rules concerning settlements on behalf of a minor child, and obtaining court approval when required.

1. Release. In exchange for the IDA, Releasors fully release and discharge 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. Releasors waive all claims against Spirit's insured up to the IDA, and agree to credit and disclose any payments received from a Spirit insured or other third party. This waiver also applies to future distributions, if any. Releasors 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. Releasors understand the IDA represents about 20% of the allowed claim. Any additional payments require Receivership Court approval and are not guaranteed or promised.

6. Assignment. Releasors assign 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 retain the right to any future distributions on the unpaid balance.

7. Indemnification. Releasors indemnify and hold Releasees harmless from all liens, claims, or demands for the IDA, including any by the Centers for Medicare and Medicaid Services ("CMS"), and are solely responsible for all CMS notification, reimbursement, and recovery obligations.

8. Taxes. Releasors have provided a valid IRS W-9, are responsible for any taxes due, and certify the accuracy of tax and payee information provided in the W-9.

9. CMS Reporting & Cooperation. Releasors 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. The signers of this agreement affirm being over eighteen, competent, acting voluntarily, and not relying on any statements outside this Release.

Signature

Releasors must sign before a Notary Public. By signing below, Releasors agree to this Release.

_____	_____
Releasor Signature	**Releasor Printed Name & Relationship to Minor Child**
_____	_____
Releasor Signature	**Releasor Printed Name & Relationship to Minor Child**

State of _____ §

County of _____ §

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

_____

Notary Public

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.

If you answer "yes" to the questions below, the SDR may request additional information before releasing your distribution payment.

Are you aware of any Lien which may apply to this claim distribution?

☐ Yes: _____ (Lienholder Name)

☐ No

Are you aware of any Medicare Lien which may apply to this claim distribution?

☐ Yes

☐ No

Are you aware of any assignment of claim agreement which may apply to this claim distribution?

☐ Yes: _____ (Assignee Name)

☐ No

I swear or affirm that I am the POC Claimant named in the Claim Information section of this form and/or am authorized to sign this form on the POC Claimant's behalf. I further swear under penalty of law that all information contained on this form is true and correct to the best of my knowledge.

_____ _____

Signature Date Title (if signing for an entity)

_____

Printed Name of Person Signing

The foregoing instrument was acknowledged before me this ___ day of _____ 20___, by means of ☐ physical presence or ☐ online notarization, by _____, and ☐ who is personally known to me or ☐ who has produced _____ as identification, and, after being sworn, subscribed to the foregoing.

_____

NOTARY PUBLIC

[Notarial Seal/Stamp]

_____

(Printed Name of Notary)

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

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)* _____