EXHIBIT A

INDIANA LIQUIDATION PROCEEDING
REGARDING
MEDICAL SAVINGS INSURANCE COMPANY, IN LIQUIDATION

PROOF OF CLAIM

A Liquidation Proceeding has been opened in Indiana, pursuant to Ind. Code 27-9-3, to consider and adjudicate claims under Indiana law as a result of the insolvency of Medical Savings Insurance Company ("MSIC").

IF YOU WERE A MEMBER/ENROLLEE OF MSIC, OR A HEALTH CARE PROVIDER WHO RENDERED SERVICES TO A MEMBER/ENROLLEE OF MSIC, AND YOU HAVE ALREADY RECEIVED PAYMENT IN FULL ON YOUR CLAIM FROM A GUARANTY ASSOCIATION, THEN YOU DO NOT NEED TO FILE A PROOF OF CLAIM.

If, however, you have any outstanding claim against MSIC then you must fill out this form completely and return it to Medical Savings Insurance Company, In Liquidation, c/o Special Deputy Liquidator, at the address shown below, by depositing it in the United States mail, first class postage prepaid, by no later than October 1, 2010. FAILURE TO HAVE THIS FORM COMPLETED, MAILED AND POSTMARKED ON OR BEFORE OCTOBER 10, 2010, WILL AFFECT YOUR LEGAL RIGHTS AND MAY WAIVE AND BAR ANY CLAIM THAT YOU MIGHT OTHERWISE HAVE.

Please file only one (1) claim per Proof of Claim form. If you have more than one (1) claim as against MSIC, you may file as many separate Proof of Claims as necessary to submit each of your individual claims.

PLEASE PRINT OR TYPE THIS SECTION

1. Name:______________________________
2. Daytime Phone Number (____) ____-______

3. Address:

__________________ ______________ _____ ______
Street Address City State Zip Code

4. Give a brief explanation of the facts and basis surrounding your claim, including the consideration on which it is based. Attach all documents which are the foundation of or otherwise provide support for the claim and identify the date on which your claim arose against MSIC (use additional pages if necessary and attach all documentation supporting your claim).

5. Identify the amount of the claim, the identity and amount of security on the claim, if any, payments made on the claim to date, if any, and the right of priority of payment or other specific rights being claimed, if any. (Use additional pages if necessary.)

____

____

____

6. Social Security or Federal ID No.: ________________________

7. By signing this Proof of Claim (this form MUST BE SIGNED), the undersigned verifies that the sum claimed is justly owing and that there is no set-off, counterclaim, or defense to the claim.

____
Printed____________________
Title (if applicable)______________

This Proof of Claim MUST BE MAILED AND POSTMARKED NO LATER THAN OCTOBER 1, 2010, addressed to the attention of:

Medical Savings Insurance Company, In Liquidation
c/o Special Deputy Liquidator
P.O. Box 68961
Indianapolis, IN 46268-0961

To Be Completed by Special Deputy Liquidator
Claim I.D. #:________________________
Postmarked Date:______________________
Received:__________________________