SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

DEBORAH TANZER,	:	
	:	
Plaintiff,	:	
	:	Index No: 114263/95
-against-	:	(Gammerman, J.)
	:	IAS Part 27
	:	P.C. No. 10448
HEALTH INSURANCE PLAN OF	:	
GREATER NEW YORK,	:	
	:	
Defendant.	:	

PROOF OF CLAIM AND RELEASE

NOTE: YOU ARE URGED TO READ CAREFULLY THE ACCOMPANYING NOTICE OF PROPOSED SETTLEMENT OF CLASS ACTION AND SETTLEMENT HEARING ("THE NOTICE"). IN ORDER TO RECEIVE BENEFITS FROM THE SETTLEMENT OF THIS ACTION (AS DESCRIBED IN THE NOTICE), CLASS MEMBERS (AS DESCRIBED IN THE NOTICE), OR THEIR AUTHORIZED REPRESENTATIVES, MUST COMPLETE THIS PROOF OF CLAIM, SIGN IT AND MAIL IT, TOGETHER WITH ANY SUPPORTING DOCUMENTS TO:

HIP
7 West 34th Street
New York, New York 10001
Attention: Vickie Hall

THIS PROOF OF CLAIM MUST BE POSTMARKED OR RECEIVED ON OR BEFORE AUGUST 21, 2000 IN ORDER TO BE ELIGIBLE TO RECEIVE BENEFITS UNDER THE SETTLEMENT.

INSTRUCTIONS

1. Please read the Notice and these Instructions carefully to determine your eligibility to receive benefits under the Settlement.

2. If you are a member of the Class as defined in the Notice and wish to participate in the Settlement, you must complete and sign this Proof of Claim and mail it back in accordance with these Instruction.

3. Your receipt of benefits under the Settlement will be determined in accordance with the provisions of the Notice entitled "The Proposed Settlement."

4. Complete the Proof of Claim as fully as possible endeavoring to provide information that will enable those reviewing your Proof of Claim to establish, or confirm the following: (i) that you underwent a surgery or procedure for which Anesthesia Services were rendered; (ii) the type of surgery or procedure you underwent; (iii) when the surgery or procedure was performed and the Anesthesia Services were rendered; (iv) that you were not covered under another applicable health insurance policy for Anesthesia Services when the surgery or procedure was performed and the Anesthesia Services were rendered; (v) that the obligation for payment of the amount incurred for Anesthesia Services still exists or was paid to your medical care provider by you or on your behalf; and (vi) that you were not reimbursed by a third party insurer for all or part of the cost of the Anesthesia Services. In the event that you cannot provide all information requested, provide all information that you know or can ascertain.

5. You must attach to this Proof of Claim form true and correct copies of any bills, receipts, canceled checks or other documents that you currently possess which relate to your Claim for Anesthesia Services benefits under this Settlement. If you have not maintained such records you may still receive benefits under the Settlement. You must sign and swear to, before a notary public the attached affidavit attesting to your surgery or procedure for which Anesthesia Services were rendered and your payment or existing obligation of payment for same.

6. Executors, administrators, guardians, conservators and trustees may complete and sign the Proof of Claim on behalf of persons represented by them, but they must identify such persons and provide proof of their authority (e.g. powers of attorney or currently effective letters testamentary or letters of administration) to complete and execute the Proof of Claim on their behalf and to bind them in accordance with the terms thereof.

7. List separately all surgeries or procedures for which Anesthesia Services were rendered. If you cannot list all surgeries or procedures in the space provided in the Proof of Claim, or if you believe that you must supply additional information with respect to any surgery or procedure, attach separate sheets to the Proof of Claim providing all the required information. The Claimant must be properly identified on each such additional sheet.

8. You must mail the completed Proof of Claim form and attachments by first class mail, or registered or certified mail, postage pre-paid, post-marked no later than

August 21, 2000 to:

HIP
7 West 34th Street
New York, New York 10001
Attention: Vickie Hall

9. We suggest that you retain copies of your Proof of Claim and all supporting documentation.

10. Any person who knowingly submits a false Proof of Claim is subject to the penalties for perjury.

11. If you desire additional information or require additional copies of the Notice or Proof of Claim, you may obtain such additional information or copies by downloading it from HIP's world-wide web site at www.hipusa.com or by contacting:

HIP
7 West 34th Street
New York, New York 10001
Attention: Vicki Hall
212-630-8480

Carl L. Stine, Esq.
Wolf Popper LLP
845 Third Avenue
New York, New York 10022
(212) 759-4600

Please do not contact the Court or the Clerk's office for information or copies.

DECLARATION

By signing this claim, I declare, under penalty of perjury, that I have read

the Instructions and the Proof of Claim and know the contents thereof, and that the information set forth in the Proof of Claim and in any documents annexed hereto is true and complete to the best of my knowledge or information and belief.

1. Claimant's name:______________________________________

2. Class Member's name (if different from Claimant)________________________________

   a. Relationship to Class Member ________________________

   b. Please attach documentation of authority to submit claim on behalf of Class Member.

3. Claimant's Address:____________________________________

Street:____

City:________________ State:___________ Zip Code:______

Telephone number (day):____________ (evening)__________

4. Date of Surgery or Procedure:____

5. Type of Surgery or Procedure:____

6. Name of Surgeon or Doctor performing Procedure:_________________________

a. Please annex copies of bill(s) for surgery or procedure and/or receipt(s) for payment made which are in your possession.

7. Name of Hospital or Medical Office in which Surgery or Procedure was performed:_______________________________________

   a. Please annex copies of bill(s) for hospital fees or receipt(s) for

payment made which are in your possession.

8. Address of Hospital or Medical Office
   in which Surgery was performed (if known):

   Street:____

City:________________ State:___________ Zip Code:______

9. Name of Anesthesiologist (if
   known):____

   a. Please annex copies of bill(s) for anesthesiologist's fees or
      receipt(s) for payment made which are in your possession.

10. Address of Anesthesiologist (if known):

   Street:____

   City:________________ State:___________ Zip Code:______

11. Name of Insurance Company
(or Companies) other than HIP that
provided hospitalization or medical insurance
coverage to Class Member on date(s)
of Surgery or Procedure:_________________________________

By submitting this Proof of Claim, I, and any Class Member I represent, submit to the jurisdiction of the Supreme Court of the State of New York, County of New York, IAS Part 27, in connection with the settlement of the above-captioned Class Action.

By submitting this Proof of Claim, I agree to be bound by the Orders of the Court and to furnish such additional information or proof with respect to the Proof of Claim as may be required.

By signing this Proof of Claim, I, and any Class Member I represent, hereby authorize any and all medical providers and insurance companies that I identify in this Proof of Claim or through discussions with HIP regarding this Proof of Claim, to release to HIP, 7 West 34th Street, New York, New York 10001, any and all medical records, insurance records, or any other information regarding my treatment, hospitalization or care, or coverage for such treatment hospitalization or care.

By submitting this Proof of Claim, I agree to allow the reviewers of my Claim to conduct reasonable investigation of my Claim as provided in the Stipulation of Settlement.

By signing this Proof of Claim, and in consideration of the benefits accruing to the Class pursuant to the Stipulation of Settlement, I, on behalf of myself, and on behalf of my heirs, executors, administrators, successors, custodians, representatives, and all other persons who may claim by or through the undersigned Class Member, do hereby release and dismiss on the merits and with prejudice with respect to HIP, and each of its present and former officers and directors, employees, agents, advisors, representatives, predecessors, affiliates, parents, subsidiaries, partners, successors, heirs, administrators, executors, and assigns of any of the foregoing, all claims of any kind which I had or have, by reason of or arising out of or relating to any claim for Anesthesia Services under an HIP Basic Direct-Pay Policy.

I affirm under the penalties of perjury that the foregoing statements are true, correct and complete.

Dated:______________________

____
Claimant's Signature

____
Title or Position (if signing in a representative capacity on behalf of the Class Member)

YOU MUST ATTACH PHOTOCOPIES OF ANY DOCUMENTS IN YOUR POSSESSION WHICH SUPPORT YOUR CLAIM, INCLUDING THE ANESTHESIOLOGIST'S BILL AND YOUR RECEIPT FOR PAYMENT.

ALL CLAIMANTS SUBMITTING A PROOF OF CLAIM MUST SIGN AND SWEAR TO, BEFORE A NOTARY PUBLIC, THE ATTACHED AFFIDAVIT.

AFFIDAVIT OF CLAIMANT

STATE OF __________________)
: ss.
COUNTY OF ________________)

__________________________, being duly sworn, deposes and says:
(Name of Claimant)

By submitting this Proof of Claim, I affirm, under the penalties of perjury, that I, or any Class Member for whom I am the legal representative, heir or successor, underwent a surgery or procedure for ______________________ on or about
(type of surgery or procedure)

_______________________for which Anesthesia Services were rendered and for which
(date of surgery or procedure)

I was billed. I (a) paid for such Anesthesia Services or (b) incurred an obligation of payment for such Anesthesia Services (circle whichever applies – (a) or (b)). I, or any Class Member for whom I am the legal representative, heir or successor, have not been reimbursed by any third party insurer for the amount I have paid or the obligation I have incurred for Anesthesia Services rendered in connection with my surgery or procedure.

____
Claimant's Signature

____
Title or Position (if signing in representative capacity on behalf of the Class Member)

Sworn to before me this
__ day of _____________, 2000

____
Notary Public