UNITED STATES BANKRUPTCY COURT
DISTRICT OF DELAWARE

PROOF OF CLAIM

In re:

Case Number:
10 11 638
10 1637

NOTE: See Reverse for List of Debtors/Case Numbers/ Important details. Other than claims under 11 U.S.C. § 503(b)(9), this form should not be used to make a claim for administrative expenses arising after the commencement of the case. A "request" for payment of an administrative expense may be filed pursuant to 11 U.S.C. § 503(a).

☐ Check box if you are aware that anyone else has filed a proof of claim relating to your claim. Attach copy of statement giving particulars.

☐ Check this box if you are the debtor or trustee in this case.

Name of Creditor and Address: the person or other entity to whom the debtor owes money or property

[redacted] 24838954001167 RJ

MARIA CASTILLO
707 CARTER STREET
MARTINSVILLE, VA 24112

2194 Voluntoor
Elm city NC-
27822.

Creditor Telephone Number (252) 443-1176 OR 276-226-7329

Name and address where payment should be sent (if different from above):

Payment Telephone Number ( )

If you have already filed a proof of claim with the Bankruptcy Court or BMC, you do not need to file again.

THIS SPACE IS FOR COURT USE ONLY

RECEIVED
NOV 08 2010
BMC GROUP

☐ Check this box to indicate that this claim amends a previously filed claim.

Claim Number (if known):

Filed on: _____

1. AMOUNT OF CLAIM AS OF DATE CASE FILED $ Estimated $26,000 total

If all or part of your claim is secured, complete item 4 below; however, if all of your claim is unsecured, do not complete item 4.

If all or part of your claim is entitled to priority, complete item 5.

☐ Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach itemized statement of interest or charges.

2. BASIS FOR CLAIM: FAILURE TO PROVIDE COBRA HEALTH INSURANCE AND UNPAID WAGES UNPAID VACATION PAY $3140, APPREASING (See instructions #2 and #3a on reverse side.)

3. LAST FOUR DIGITS OF ANY NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR: _____

3a. Debtor may have scheduled account as: _____

4. SECURED CLAIM (See instruction #4 on reverse side.)

Check the appropriate box if your claim is secured by a lien on property or a right of set off and provide the requested information.

Secured Claim Amount: $ _____ DO NOT include the priority portion of your claim here.

Unsecured Claim Amount: $ _____

Nature of property or right of setoff:

☐ Real Estate ☐ Motor Vehicle ☐ Other _____

Value of Property: $ _____ Annual Interest Rate: _____ %

Amount of arrearage and other charges as of time case filed included in secured claim, if any: $ _____ Basis for Perfection: _____

5. PRIORITY CLAIM

Unsecured Priority Claim Amount: $ _____ Include ONLY the priority portion of your unsecured claim here.

☐ Amount of Claim Entitled to Priority under 11 U.S.C. §507(a). If any portion of your claim falls in one of the following categories, check the box and state the amount.

You MUST specify the priority of the claim:

☐ Domestic support obligations under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).

☑ Wages, salaries, or commissions (up to $11,725*), earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(4).

☑ Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(5).

☐ Up to $2,600* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use - 11 U.S.C. § 507(a)(7).

☐ Taxes or penalties owed to governmental units - 11 U.S.C. § 507(a)(8).

☐ Other - Specify applicable paragraph of 11 U.S.C. § 507(a) (____).

Amounts are subject to adjustment on 4/1/13 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment

SECTION 503(b)(9) CLAIM $ _____

☐ Check this box if your claim is for the value of goods received by the debtor within 20 days before the date of commencement of the case (11 U.S.C. § 503(b)(9)). Include the amount of such claim in the space for "Amount entitled to priority" above.

6. CREDITS: The amount of all payments on this claim has been credited for the purpose of making this proof of claim.

7. SUPPORTING DOCUMENTS: *Attach redacted copies of supporting documents,* such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, and security agreements. You may also attach a summary. Attach redacted copies of evidence of perfection of a security interest. (See instruction 7 and definition of "redacted" on reverse side.) If the documents are not available, please explain.

DATE-STAMPED COPY: To receive an acknowledgment of the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

The original of this completed proof of claim form must be sent by mail or hand delivered (FAXES NOT ACCEPTED) so that it is actually received on or before 4:00 pm, prevailing Eastern Time on August 6, 2010 for Non-Governmental Claimants OR on or before November 15, 2010 for Governmental Units.

THIS SPACE FOR COURT USE ONLY

Barcalounger
00380

BY MAIL TO:
BMC Group, Inc
Attn: Barcalounger Corporation Claims Processing
PO Box 3020
Chanhassen, MN 55317-3020

BY HAND OR OVERNIGHT DELIVERY TO:
BMC Group, Inc
Attn: Barcalounger Corporation Claims Processing
18750 Lake Drive East
Chanhassen, MN 55317

DATE
7/26/2010

SIGNATURE: The person filing this claim must sign it. Sign and print name and title, if any, of the creditor or other person authorized to file this claim and state address and telephone number if different from the notice address above. Attach copy of power of attorney, if any.

[signature]

Penalty for presenting fraudulent claim is a fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 AND 3571

Chan M. Park, M. D.

Chan M. Park Family Practice

6460 Greensboro Road
Ridgeway, Virginia 24148
Phone: 276-956-2047 • Fax: 276-956-1637

August 2, 2010

Re: Ms. Maria Y. Castillo
DOB: 08/07/1954

To Whom It May Concern:

I have evaluated Ms. Castillo and do recommend that she be evaluated by an orthopedist for her hand and wrist pain and numbness, It is possible that the orthopedist may recommend injection or surgery for probable carpal tunnel syndrome.

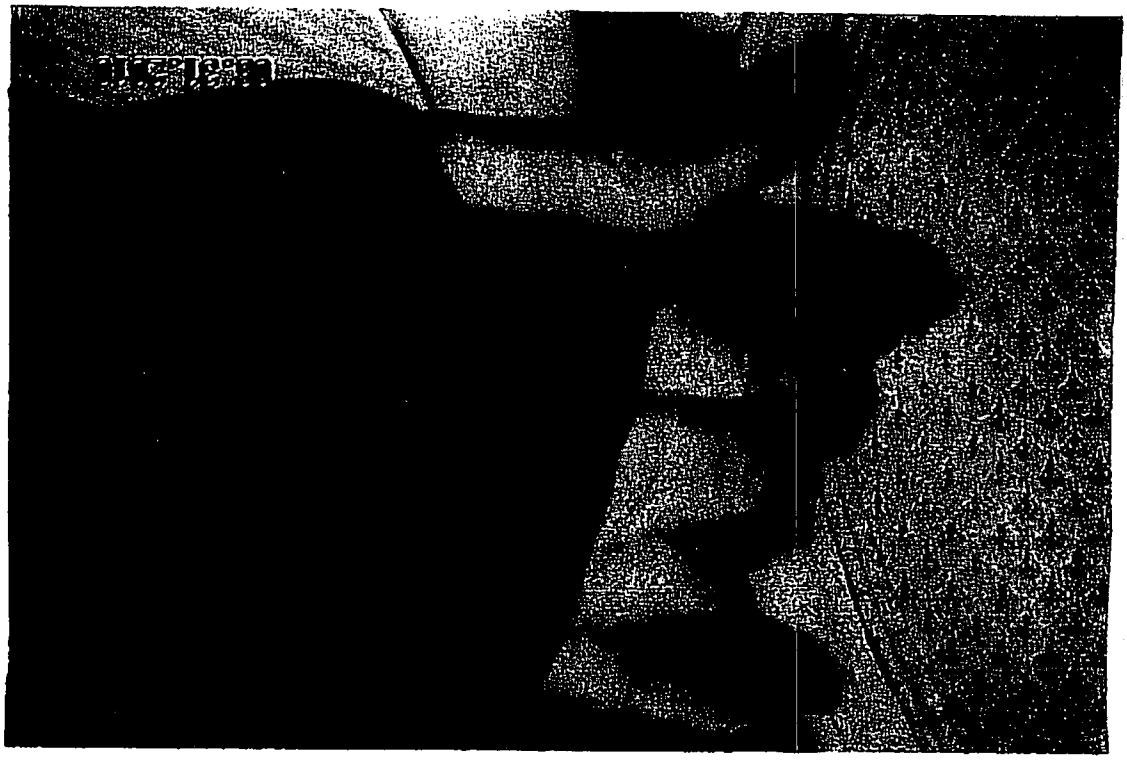
Because carpal tunnel syndrome is associated with repetitive use, there may have been some worsening due to Ms. Castillo's repetitive work previously at American Furniture of Martinsville. Thank you.

Sincerely,

Chan M. Park, M.D.

Case Number
10-11637 CB1S7

it is my finger look like



Anthem.

RESPONSE REQUIRED

August 31, 2010

MARIA CASTILLO
707 CARTER ST
MARTINSVILLE, VA 24112

Amount Due: $ 659.43
Termination Date: 04/14/2010
Reference Number: H411079

Dear MARIA CASTILLO,

As you were previously informed, an audit has identified that your prescription drug card was used for benefits after your prescription coverage terminated with Anthem Blue Cross and Blue Shield. Since you were not eligible for prescription plan benefits on these fill dates, Anthem Blue Cross and Blue Shield is due full reimbursement of the amounts paid.

As a service to our former customers, we have asked Rawlings Financial Services LLC to assist in filing these claims directly with your new health insurance plan for reimbursement in lieu of requesting payment directly from you. Please call Diane Watson at Rawlings Financial Services LLC at 1-888-258-8060 ext. 2326 between 8:30 AM and 5:00 PM (Eastern Time) to obtain the necessary information to submit these claims to your new health insurance plan.

Specific claims and other protected health information may only be discussed with the patient unless written authorization to discuss the information with another party is given in advance by the patient.

SUMMARY OF BENEFITS PAID AFTER TERMINATION		
Dates of Fill	**Number of Claims Paid**	**Total Amount Paid**
04/23/2010– 04/26/2010	6	$ 659.43

Thank you for your prompt attention to this matter.

Anthem Blue Cross and Blue Shield

MARTINSVILLE VA 24115
MARTINSVILLE VA 24115

11768k
5392M
FR06

ADDRESS SERVICE REQUESTED

MARIA CASTILLO

>15027 7667596 001 092096
MARIA CASTILLO
2194 VOLUNTEER RD
ELM CITY NC 27822-8046

Please Include Security Code From Back Of Card	
CHECK CARD USING FOR PAYMENT	
MASTERCARD ☐ VISA ☐	
CARD NUMBER	EXP. DATE
CARDHOLDER NAME	SECURITY CODE
SIGNATURE	AMOUNT

REMIT TO:

BONE AND JOINT CENTER
PO BOX 4788
MARTINSVILLE VA 24115-4788

PLEASE RETURN THIS PORTION WITH PAYMENT

Office Phone Number	Statement Date	Your Account Number	Page No.	Patient Balance	SHOW AMOUNT PAID HERE $
(276) 670-7068	08/06/10	442375	01	78.00	

CHARGES APPEARING ON THIS STATEMENT ARE NOT INCLUDED ON ANY HOSPITAL BILL OR STATEMENT

DATE	PROVIDER NAME	EXPLANATION OF ACTIVITY	PATIENT NAME	CHARGES AND DEBITS	PAYMENTS AND CREDITS	BALANCE
60710		BALANCE FORWARD				78.00

ement
: 08/06/10

PLEASE INDICATE YOUR ACCOUNT NUMBER WHEN CALLING OUR OFFICE: 442375

CURRENT	30-60 DAYS	60-90 DAYS	> 90 DAYS	TOTAL	INS PENDING	PATIENT BALANCE PAY THIS AMOUNT
			78.00	78.00	0.00	78.00

D INQUIRIES / PAYMENTS TO:
BONE AND JOINT CENTER
PO BOX 4788
MARTINSVILLE VA 24115

(276) 670-7068

27 7667596 015028 015028 00001/00001 920966902

NOTE: Charges and payments not appearing on this statement will appear on next month's statement.

920965

Dentist's pre-treatment estimate
Dentist's statement of actual services
Provider ID #

2. ☐ Medicaid Claim ☐ EPSDT Prior Authorization # Patient ID #

3. Carrier name and address

4. Patient name (first, m.i., last): Maria Castillo

5. Relationship to employee: ☒ self ☐ child ☐ spouse ☐ other

6. Sex: m ☐ f ☒

7. Patient birthdate: MM 8 DD 7 YYYY 54

8. If full time student: school / city

9. Employee/subscriber name and mailing address: Maria Castillo, 2194 Volunteer Road, Elm City, NC 27822

10. Employee/subscriber dental plan I.D. number

11. Employee/Subscriber birthdate: MM 8 DD 7 YYYY 54

12. Employer (company) name and address

13. Group number

14. Is patient covered by another dental plan? yes (no) If yes, complete 15-a. Is patient covered by a medical plan? yes no

15-a. Name and address of carrier(s)

15-b. Group no.(s)

16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different than patient's)

17-b. Employees/subscriber dental plan I.D. number

17-c. Employee/subscriber birthdate: MM 8 DD 7 YYYY 54

18. Relationship to patient: ☒ self ☐ parent ☐ spouse ☐ other

19. I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

gned (Patient* — see reverse) Date

20. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

Signed (Employee/subscriber) Date

21. Name of Billing Dentist or Dental Entity: Craig B. Lietrich DMD

22. Address where payment should be remitted: P.O.Box 4402

23. City, State, Zip: Martinsville, VA 24115-4402

24. Dentist Soc. Sec. or T.I.N. (see reverse): 54-2058929

25. Dentist license no.: 7580

26. Dentist phone no.: 276-632-0010

27. First visit date current series

28. Place of treatment: Office X Hosp. ECF Other

29. Radiographs or models enclosed? No Yes How many?

30. Is treatment result of occupational illness or injury? No X Yes — If yes, enter brief description and dates

31. Is treatment result of auto accident? No X

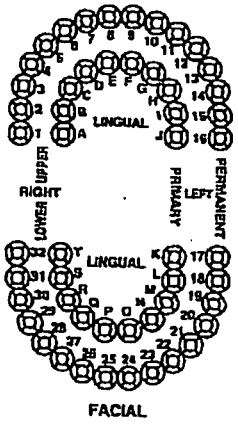
32. Other accident? No X

33. If prosthesis, is this initial placement? X — (If no, reason for replacement)

34. Date of prior placement

35. Is treatment for orthodontics? X — If services already commenced enter: Date appliances placed: Mos. treatment remaining:

36. Identify missing teeth with "X"



37. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32 — Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee
5		bridge abutment		D6752	650 —
6		bridge abutment		D6752	650 —
11		bridge abutment		D6752	650 —
12		bridge abutment		D6752	650 —
7		Pontic		D6242	650 —
8		Pontic		D6242	650 —
9		Pontic		D6242	650 —
10		Pontic		D6242	650 —

For administrative use only

38. Remarks for unusual services

NPI

1275648347

39. I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

Signed (Treating Dentist) 7580 License Number Date

40. Address where treatment was performed: 904 Brookdale Street, Martinsville, VA, 24115 (City, State, Zip)

41. Total fee charged: 5,200 00

42. Payment by other plan

Max Allowable

Deductible

Carrier %

JULY 20 OF 2010:

TO; WHOM CONCERNING:

I use this way to let know my complain for damages to personal y labor and I requiren my pay for $ 26,000.00 (twenty six tousends dollar s 00/100) for shut down out notification, this money incluue my vacation 's, wages and insurance cancelation out of right time,titis means expensas for medical & dental bills no pay for insurance when and postube cover,for preexisting condicions on my raiht arm and hand requiere and operation on my four I was let know my manager mr. Bill Tussing and the human resources manager miss .Bervely they know and approved my operation when the next day the company shut down. I 'was work for barcalounger corporation for the last 10 years the I nsurange was canceled on april 14 ot 2010. I was still working to my last day on april 15 2010 and the company drop for my pay check the pay for my Insurance until april 2010 why they canceled before my last payment? . Now Insurance no want to my dentist bills before april 15,2010 this no Justice. My dentist bill it is for $ 5,200 dls. When Barcalounger move to Martinsville VA. From Rocky Mount N.C. we move with the company now we move again to our house back because we no have job on Virginia (Martinsville) and we expense money for Go back to our home plus we lost our deposit on the rent on the house on Martinsville because the land lord no give the money back ,I feel to much stress and I depresive for lot of problems for this case .

BUT GOD IS JUSTICE AND I WAIT FOR HIS HOLY SOLUCION, THANKS FOR EVERYTHING AND GOD BLESS YOU.

SINCERALY.

Maria Y Castillo

My.adress. 2194 Volunteer rd

Elm City N.C. 27822

My. Phone #(252 443 11 76 home cell . 276 226 73 29

276 226 7331