

Fill in this information to identify the case:

Debtor 1 Curae Health Inc.
Debtor 2 _____
(Spouse, if filing)
United States Bankruptcy Court MIDDLE DISTRICT OF TENNESSEE
Case number: 18-05665

FILED
U.S. Bankruptcy Court
MIDDLE DISTRICT OF TENNESSEE
8/28/2018
MATTHEW T. LOUGHNEY, Clerk

**Official Form 410
Proof of Claim****04/16**

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents**; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.

Part 1: Identify the Claim

1. Who is the current creditor?	<u>Teleflex Medical Incorporated</u> Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor used with the debtor _____	
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____	
3. Where should notices and payments to the creditor be sent? Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	Where should notices to the creditor be sent? <u>Teleflex Medical Incorporated</u> Name <u>3015 Carrington Mill Boulevard, Suite 3</u> <u>Morrisville, NC 27560-8871</u> Contact phone <u>919-361-4135</u> Contact email <u>christopher.lynch@teleflex.com</u> Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____	Where should payments to the creditor be sent? (if different) <u>PO Box 601608</u> Name Charlotte, NC 28260-1608 Contact phone <u>919-361-4135</u> Contact email <u>christopher.lynch@teleflex.com</u>
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY	
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____	

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. Do you have any number you use to identify the debtor?	<div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor:</div><div style="border-bottom: 1px solid black; width: 150px; text-align: center;">0543</div></div>
7. How much is the claim?	<div style="display: flex; justify-content: space-between;"><div style="width: 40%;">\$ <u>172.55</u></div><div>Does this amount include interest or other charges? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).</div></div>
8. What is the basis of the claim?	<p>Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card. Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c). Limit disclosing information that is entitled to privacy, such as healthcare information.</p> <p style="text-align: center; border-bottom: 1px solid black;">GOODS SOLD</p>
9. Is all or part of the claim secured?	<div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property.</div> <div>Nature of property: <input type="checkbox"/> Real estate. If the claim is secured by the debtor's principal residence, file a <i>Mortgage Proof of Claim Attachment</i> (Official Form 410-A) with this <i>Proof of Claim</i>. <input type="checkbox"/> Motor vehicle <input type="checkbox"/> Other. Describe: _____</div> <div>Basis for perfection: _____</div> <p>Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)</p> <div style="display: flex; justify-content: space-between;"><div>Value of property:</div><div>\$ _____</div></div> <div style="display: flex; justify-content: space-between;"><div>Amount of the claim that is secured:</div><div>\$ _____</div></div> <div style="display: flex; justify-content: space-between;"><div>Amount of the claim that is unsecured:</div><div>\$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)</div></div> <div style="display: flex; justify-content: space-between; margin-top: 20px;"><div>Amount necessary to cure any default as of the date of the petition:</div><div>\$ _____</div></div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"><div>Annual Interest Rate (when case was filed)</div><div>_____ %</div></div> <div style="margin-top: 10px;"><input type="checkbox"/> Fixed <input type="checkbox"/> Variable</div>
10. Is this claim based on a lease?	<div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition. \$ _____</div>
11. Is this claim subject to a right of setoff?	<div><input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____</div>

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. <i>Check all that apply.</i>	Amount entitled to priority
A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.	<input type="checkbox"/> Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	\$ _____
	<input type="checkbox"/> Up to \$2,850* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	\$ _____
	<input type="checkbox"/> Wages, salaries, or commissions (up to \$12,850*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	\$ _____
	<input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	\$ _____
	<input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	\$ _____
	<input type="checkbox"/> Other. Specify subsection of 11 U.S.C. § 507(a)(_) that applies	\$ _____
* Amounts are subject to adjustment on 4/01/19 and every 3 years after that for cases begun on or after the date of adjustment.		

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157 and 3571.

Check the appropriate box:

- ☒ I am the creditor.
☐ I am the creditor's attorney or authorized agent.
☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this Proof of Claim serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this Proof of Claim and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 8/28/2018
MM / DD / YYYY

/s/ CHRISTOPHER L LYNCH

Signature

Print the name of the person who is completing and signing this claim:

Name	CHRISTOPHER L LYNCH		
	First name	Middle name	Last name
Title	Sr. Lead Credit and Collections Specialist		
Company	TELEFLEX MEDICAL INCORPORATED		
Address	Identify the corporate servicer as the company if the authorized agent is a servicer 3015 Carrington Mill Blvd., #300 Number Street Morrisville, NC 27560-8871 City State ZIP Code		
Contact phone	919-361-4135	Email	christopher.lynch@teleflex.com

Account Statement/ Open Item Listing

Account #		Statement Date
110543		08/28/2018
Page	Currency	Terms of Payment
1 of 1	USD	Cash in advance-

Northwest Mississippi Medical
Center
PO Box 1218
CLARKSDALE MS 38614-7202
USA

Contact Information for questions on Statement

Name Erin Burcher
Telephone
Fax
E-mail: Erin.Burcher@teleflex.com

Remittance Information

By Regular Mail

Teleflex Medical
PO Box 601608
Charlotte, NC 28260-1608

By Wire

Bank: Wells Fargo Bank, N.A.
Address: San Francisco, CA
Acct #: 2000003325667
Routing/ABA #: 121000248
SWIFT Code: WFBUS6S

By Overnight

Teleflex Funding Corporation
Lockbox # 601608
1525 West W.T. Harris Blvd - 2C2
Charlotte, NC 28262

Document #	PO #/Check	Reference	Item Date	Due Date	Docum. Type	Reason Code	Amount
95431177	749-6641196		01/17/2018	02/16/2018	RV		143.75
95476105	749-6657584		02/02/2018	03/04/2018	RV		28.80

CURRENT	OVERDUE 1-30	OVERDUE 31-60	OVERDUE 61-90	OVERDUE 91+	ACCT BALANCE
0.00	0.00	0.00	0.00	172.55	\$172.55

**Invoice**

No.	Date	Page	Due Date
95431177	01/17/2018	1 of 1	02/16/2018
Payer Account No. 110543			

Bill To Party **Account No. 110543**
Northwest Mississippi Medical
Center
1970 Hospital Drive
Clarksdale MS 38614-7202
USA

Ship To Party **Account No. 110543**
Northwest Mississippi Medical
Center
1970 Hospital Drive
Clarksdale MS 38614-7202
USA

Payment Remittance Address:

Teleflex Medical
PO Box 601608
Charlotte, NC 28260-1608

Wire Transfer Remittance:

Wells Fargo Bank, NA, Charlotte, NC
Account No. 2000003325667
Routing/ABA No. 121000248
SWIFT Code: WFBUS6S

Overnight Remittance Address:

Teleflex Medical c/o Wells Fargo Bank,
NA
PO Box 601608
1525 West W.T. Harris Blvd - 2C2
Charlotte, NC 28262

Purchase Order No.	Sales Order No.	Order Placed By	Delivery No.	Carrier/Level of Service
749-6641196	3894805	YATASHA MUSKIN	8001983564	FEDERAL EXPRESS
Tracking No.	Freight Terms	Incoterms	Payment Terms	Currency
613551085086390	Collect	FOB ORIGIN	Net 30	USD

Line	Material	Material Description	UOM	Shipped Qty	Back Order	Unit Price	Total
000010	MAD300	MAD Nasal without Syringe	BX	1	0	143.75	143.75
Brand: LMA							
		Batch No. 73L1700121					
		Exp. Date 11/07/2020					

Comments:

Sub-Total	143.75
Tax	0.00
Total USD	143.75

The terms on our Acknowledgment and Invoices state Teleflex's entire contract. Teleflex shall not be bound by any different, additional or conflicting terms and conditions contained in Buyer's Purchase Order unless expressly agreed to in writing by Teleflex. Teleflex's Acknowledgment will not hereafter be subject to any change, modification or conflicting language without Teleflex's prior written consent.

To access our terms and conditions please visit https://www.teleflex.com/global/legal/General_Terms_and_Conditions_NA.pdf

Teleflex Medical Incorporated
3015 Carrington Mill Blvd Morrisville, NC 27560 USA
Tel 866-246-6990 International +19193613964 Fax
Email cs@teleflex.com www.teleflex.com

EIN: 95-1867330

**Packing List**Delivery No.
8001983564Delivery Date
01/16/2018Page
1 of 1

Sold To Party Account No. 110543
Northwest Mississippi Medical
Center
PO Box 1218
Clarksdale MS 38614-7202
USA

Ship To Party Account No. 110543
Northwest Mississippi Medical
Center
1970 Hospital Drive
Clarksdale MS 38614-7202
USA

Forwarding Agent Account No. 600307
FEDERAL EXPRESS
DEPT LA
PO Box 21415
PASADENA CA 91185-1415

Purchase Order No.	Sales Order	Shipping Point	Freight Terms	Incoterms
749-6641196	3894805	Olive Branch Ship Point (Std)	Collect	FOB - ORIGIN
Tracking No.	Container	Seal	Transportation	Vessel
613551085086390			FEDERAL EXPRESS	
Delivery Priority	Route			
25 FedEx Ground	STDRTE Standard Route			

Line	Material	Brand	Material Description	UOM	Order Qty.	Back Ord. Qty.	Quantity Shipped	Weight
10	MAD300	LMA	MAD Nasal without Syringe Batch No. 73L1700121 Shipto PO: 500131748247	BX 11/07/2020	1	0	1	0.300 LB

Total Shipping Units: 00001
Weight: 1.300 LB

Unit of Measure Description:
BOX

Total Units:
1.000

Comments:

Teleflex Medical Incorporated

PO Box 3015 Carrington Mill Blvd Morrisville, NC 27560 USA
Tel 800 666 9911 Email teleflex@teleflex.com www.teleflex.com

3564



August 28, 2018

Dear Customer:

The following is the proof-of-delivery for tracking number **613551085086390**.

Delivery Information:

Status:	Delivered	Delivery location:	1970 HOSPITAL DR Clarksdale, MS 38614
Signed for by:	KTAYLOR	Delivery date:	Jan 19, 2018 12:54
Service type:	FedEx Ground		
Special Handling:			

K. TAYLOR
#20, 12:49, 31 Del, 0 NonDel

Shipping Information:

Tracking number:	613551085086390	Ship date:	Jan 18, 2018
		Weight:	0.8 lbs/0.4 kg

Recipient:

Center
Northwest Mississippi Medical
1970 Hospital Drive
Clarksdale, MS 38614 US

Reference

Purchase order number:

Shipment Id

Invoice number

Shipper:

Customer Service
TELEFLEX MEDICAL
11245 N DISTRIBUTION COVE
OLIVE BRANCH, MS 38654 US

749-6641196

8001983564

613551085086390

1006682723

Thank you for choosing FedEx.

**Invoice**

No.	Date	Page	Due Date
95476105	02/02/2018	1 of 1	03/04/2018
Payer Account No. 110543			

Bill To Party **Account No. 110543**
Northwest Mississippi Medical
Center
1970 Hospital Drive
Clarksdale MS 38614-7202
USA

Ship To Party **Account No. 110543**
Northwest Mississippi Medical
Center
1970 Hospital Drive
Clarksdale MS 38614-7202
USA

Payment Remittance Address:

Teleflex Medical
PO Box 601608
Charlotte, NC 28260-1608

Wire Transfer Remittance:

Wells Fargo Bank, NA, Charlotte, NC
Account No. 2000003325667
Routing/ABA No. 121000248
SWIFT Code: WFBUS6S

Overnight Remittance Address:

Teleflex Medical c/o Wells Fargo Bank,
NA
PO Box 601608
1525 West W.T. Harris Blvd - 2C2
Charlotte, NC 28262

Purchase Order No.	Sales Order No.	Order Placed By	Delivery No.	Carrier/Level of Service
749-6657584	3927352	YATASHA MUSKIN	8002024113	FEDERAL EXPRESS
Tracking No.	Freight Terms	Incoterms	Payment Terms	Currency
613551085142263	Collect	FOB ORIGIN	Net 30	USD

Line	Material	Material Description	UOM	Shipped Qty	Back Order	Unit Price	Total
000010	18542036	ADJ FLANGE NON LATEX NASA	BX	1	0	28.80	28.80
Brand: Rusch		Batch No. 17J07					
		Exp. Date 09/30/2022					
Cust. Part No.		223710					

Comments:

Sub-Total	28.80
Tax	0.00
Total USD	28.80

The terms on our Acknowledgment and Invoices state Teleflex's entire contract. Teleflex shall not be bound by any different, additional or conflicting terms and conditions contained in Buyer's Purchase Order unless expressly agreed to in writing by Teleflex. Teleflex's Acknowledgment will not hereafter be subject to any change, modification or conflicting language without Teleflex's prior written consent.

To access our terms and conditions please visit https://www.teleflex.com/global/legal/General_Terms_and_Conditions_NA.pdf

Teleflex Medical Incorporated EIN: 95-1867330
3015 Carrington Mill Blvd Morrisville, NC 27560 USA
Tel 866-246-6990 International +19193613964 Fax
Email cs@teleflex.com www.teleflex.com

**Packing List**Delivery No.
8002024113Delivery Date
02/01/2018Page
1 of 1

Sold To Party	Account No. 110543	Ship To Party	Account No. 110543	Forwarding Agent	Account No. 600307
Northwest Mississippi Medical		Northwest Mississippi Medical		FEDERAL EXPRESS	
Center		Center		DEPT LA	
PO Box 1218		1970 Hospital Drive		PO Box 21415	
Clarksdale MS 38614-7202		Clarksdale MS 38614-7202		PASADENA CA 91185-1415	
USA		USA			

Purchase Order No.	Sales Order	Shipping Point	Freight Terms	IncoTerms
749-6657584	3927352	Olive Branch Ship Point (Std)	Collect	FOB - ORIGIN
Tracking No.	Container	Seal	Transportation	Vessel
613551085142263			FEDERAL EXPRESS	
Delivery Priority	Route			
25 FedEx Ground	STD RTE Standard Route			

Line	Material	Brand	Material Description	UOM	Order Qty.	Back Ord. Qty.	Quantity Shipped	Weight
10	18542036	Rusch	ADJ FLANGE NON LATEX NASA Cust Part No. 223710 Batch No. 17J07 Shipto PO: 500133846972	BX	1	0	1	0.300 LB
			09/30/2022					

Total Shipping Units: 00001
Weight: 1.300 LBUnit of Measure Description:
BOXTotal Units:
1.000

Comments:

Teleflex Medical Incorporated

PO Box 3015 Carrington Mill Blvd Morrisville, NC 27560 USA

Tel 800-666-9911 Fax 800-666-9911 Email teleflexcorp@teleflex.com www.teleflex.com

4113



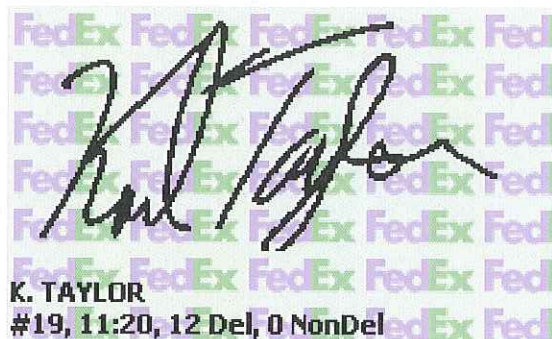
August 28, 2018

Dear Customer:

The following is the proof-of-delivery for tracking number **613551085142263**.

Delivery Information:

Status:	Delivered	Delivery location:	1970 HOSPITAL DR Clarksdale, MS 38614
Signed for by:	KTAYLOR	Delivery date:	Feb 5, 2018 11:23
Service type:	FedEx Ground		
Special Handling:			



K. TAYLOR
#19, 11:20, 12 Del, 0 NonDel

Shipping Information:

Tracking number:	613551085142263	Ship date:	Feb 2, 2018
		Weight:	0.8 lbs/0.4 kg

Recipient:

Center
Northwest Mississippi Medical
1970 Hospital Drive
Clarksdale, MS 38614 US

Reference

Purchase order number:

Shipment Id

Invoice number

Shipper:

Customer Service
TELEFLEX MEDICAL
11245 N DISTRIBUTION COVE
OLIVE BRANCH, MS 38654 US

749-6657584

8002024113

613551085142263

1006737574

Thank you for choosing FedEx.

MIDDLE DISTRICT OF TENNESSEE

Claims Register

[3:18-bk-05665 Curae Health Inc.](#)

Judge: Charles M Walker

Chapter: 11

Office: Nashville

Last Date to file claims:

Trustee:

Last Date to file (Govt):

Creditor: (6720140)
Teleflex Medical Incorporated
3015 Carrington Mill Boulevard,
Suite 3
Morrisville, NC 27560-
8871

Claim No: 1
Original Filed
Date: 08/28/2018
Original Entered
Date: 08/28/2018

Status:
Filed by: CR
Entered by: admin
Modified:

Amount claimed: \$172.55

History:

[Details](#) [1-1](#) 08/28/2018 Claim #1 filed by Teleflex Medical Incorporated, Amount claimed: \$172.55 (admin)

Description:

Remarks: (1-1) Account Number (last 4 digits):0543

Claims Register Summary

Case Name: Curae Health Inc.

Case Number: 3:18-bk-05665

Chapter: 11

Date Filed: 08/24/2018

Total Number Of Claims: 1

Total Amount Claimed*	\$172.55
Total Amount Allowed*	

*Includes general unsecured claims

The values are reflective of the data entered. Always refer to claim documents for actual amounts.

	Claimed	Allowed
Secured		
Priority		
Administrative		