

UNITED STATES BANKRUPTCY COURT FOR THE DISTRICT OF DELAWARE		PROOF OF CLAIM		 <small>s130364</small> Scheduled Claim Ref # 2-F7-12967 YOUR CLAIM IS SCHEDULED AS UNKNOWN UNSECURED DISPUTED UNLIQUIDATED	
In re Fleming Companies, Inc		Case Number 03-10945			
NOTE This form should not be used to make a claim for an administrative expense 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.				<input type="checkbox"/> 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. <input checked="" type="checkbox"/> Check box if you have never received any notices from the bankruptcy court in this case. <input type="checkbox"/> Check box if this address differs from the address on the envelope sent to you by the court.	
Name of Creditor and Address <div style="text-align: right; font-size: small;">0354429381406</div> BERGER AUDREY M 875 BAYARD AVENUE SAINT PAUL MN 55102				The amounts reflected above constitute your claim as scheduled by the Debtor. If you agree with the amounts set forth herein and have no other claim against the Debtor, you do not need to file this proof of claim EXCEPT as stated below. If the amounts shown above are listed as Contingent Unliquidated or Disputed, a proof of claim must be filed. If you have already filed a proof of claim with the Bankruptcy Court or BMC, you do not need to file again.	
Creditor Telephone Number ()		CREDITOR TAX ID #		ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR Check here <input type="checkbox"/> replaces or amends a previously filed claim dated _____ if this claim	
1 BASIS FOR CLAIM <input type="checkbox"/> Goods sold <input checked="" type="checkbox"/> Personal injury/wrongful death <input type="checkbox"/> Retiree benefits as defined in 11 U.S.C. § 1114(a) <input type="checkbox"/> Services performed <input type="checkbox"/> Taxes <input type="checkbox"/> Wages, salaries, and compensation (Fill out below) <input type="checkbox"/> Money loaned <input type="checkbox"/> Other (describe briefly) _____ Your social security number _____ Unpaid compensation for services performed from _____ to _____ <div style="text-align: right; font-size: small;">(date) (date)</div>					
2 DATE DEBT WAS INCURRED <u>2-17-03</u> 3 IF COURT JUDGMENT, DATE OBTAINED _____					
4 TOTAL AMOUNT OF CLAIM AS OF PETITION DATE \$ _____ (unsecured) \$ _____ (secured) \$ _____ (unsecured priority) \$ <u>1844.78</u> (total)					
If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below. <input type="checkbox"/> Check this box if claim includes interest or other charges in addition to the principal amount of the claim. Attach itemized statement of all interest or additional charges.					
5 SECURED CLAIM <input type="checkbox"/> Check this box if your claim is secured by collateral (including a right of setoff). Brief description of collateral: <input type="checkbox"/> Real Estate <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other _____ Value of collateral \$ _____ Amount of arrearage and other charges at time case filed included in secured claim above, if any \$ _____			6 UNSECURED PRIORITY CLAIM <input type="checkbox"/> Check this box if you have an unsecured priority claim. Specify the priority of the claim: <input type="checkbox"/> Wages, salaries, or commissions (up to \$4,650*) earned within 90 days before filing of the bankruptcy petition or cessation of the Debtor's business, whichever is earlier. 11 U.S.C. § 507(a)(3) <input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(4) <input type="checkbox"/> Up to \$2,100* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(6) <input type="checkbox"/> Alimony, maintenance, or support owed to a spouse, former spouse, or child. 11 U.S.C. § 507(a)(7) <input type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8) <input type="checkbox"/> Other: Specify applicable paragraph of 11 U.S.C. § 507(a) _____ <small>Amounts are subject to adjustment on 4/1/01 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.</small>		
7 CREDITS The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim.					
8 SUPPORTING DOCUMENTS <u>Attach copies of supporting documents</u> , such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, security agreements, and evidence of perfection of lien. DO NOT SEND ORIGINAL DOCUMENTS. If the documents are not available, explain. If the documents are voluminous, attach a summary.					
9 DATE-STAMPED COPY To receive an acknowledgment of your claim, please enclose a self-addressed stamped envelope and an additional copy of this proof of claim.					
The original of this completed proof of claim form must be sent by mail or hand delivered (FAXES NOT ACCEPTED) so that it is received on or before 4:00 p.m., September 15, 2003, Pacific Daylight Time.				THIS SPACE FOR COURT FILED AUG 12 2003 BMC <small>Fleming Companies Claim</small> 	
BY MAIL TO Bankruptcy Management Corporation P.O. BOX 900 El Segundo, CA 90245-0900		BY HAND OR OVERNIGHT DELIVERY TO Bankruptcy Management Corporation 1330 East Franklin Avenue El Segundo, CA 90245		DATE SIGNED <u>8-6-03</u>	
SIGN and print the name and title, if any, of the creditor or other person authorized to file this claim (attach copy of power of attorney, if any). <div style="text-align: center;"> <u>AUDREY M. BERGER</u> <u>Audrey M. Berger</u> </div>					

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

See Other Side For Instructions

03460

OFFICE OF

PROVIDER INFORMATION

Kenneth F. Dayton, D.D.S., P.A.
1401 Lehigh Avenue
St. Paul, MN 55105
(612) 551-5559

Dr. Kenneth F. Dayton
Federal Tax ID# 41-0900000
State License #. 7150

STATEMENT FOR

Andrew Berger
576 Maynard Ave
St. Paul, MN 55102

Date 06/05/2002
Acct. No. 1500100

Date	Name	Proc Code	Description	Tooth No.	Charge
02/18/2002	Andrew	D0220	Intraoral X-ray, Fast Film		17.00
02/18/2002	Andrew	D0220	Intraoral X-ray, Additional Film		17.00
02/18/2002	Andrew	D0140	Limited Oral Evaluation		51.00
02/19/2002	Andrew	D2940	Sedative Filling	7	25.00
02/19/2002	Andrew	D2940	Sedative Filling	8	25.00
04/08/2002	Andrew	D2712	Crown Porcelain Fused, Noble Metal	7	700.00
04/08/2002	Andrew	D2712	Crown Porcelain Fused, Noble Metal	8	700.00
06/10/2002	Andrew		100.00 submitted to EOLB		
06/10/2002	Andrew		100.00 submitted to EOLB		

Paid by Andrew Berger
6/3/03
Ch no 11258

Total Due: 1710.00

STATEMENT

Dale V Olson, D D S
393 N Dunlap Suite 220
St Paul, MN 55104
(651)645-6429

ACCOUNT NUMBER
3312100

PAGE
1

CHARGES OR PAYMENTS AFTER May 13, 2003

BILLING DATE

WILL APPEAR ON NEXT STATEMENT

"X" payment type and enter amount paid

- ☐ CHECK
☐ VISA
☐ MASTERCARD
☐ DISCOVER

Audrey Berger
875 Bayard Avenue
St Paul, MN

55102

AMOUNT ENCLOSED

card
number
cardholder
signature

valid
thru

date

ALL CHARGES ON THIS STATEMENT DUE ON PRESENTATION PLEASE RETURN
THIS PORTION OF STATEMENT WITH PAYMENT

PLEASE RETAIN THIS PORTION OF STATEMENT FOR YOUR RECORDS

DATE	DESCRIPTION	REFERENCE	CHARGES	CREDITS
03/29/03	PREVIOUS BALANCE		126 00	
04/15/03	Finance Charge	Account	1 89	
05/13/03	Finance Charge	Account	1 89	

*Paid by Audrey Berger
5/20/03
Master card
Talked to Ken*

ESTIMATED INSURANCE COVERAGE 0 00

CURRENT	30 DAYS	60 DAYS	90 DAYS	NEW BALANCE
129 78	0 00	129 78	0 00	129 78

Dale V Olson, D D S , 393 N Dunlap Suite 220, St Paul, MN 55104

PLEASE
PAY

AMOUNT DUE
129 78

STATEMENT

Dale V Olson, D D S
393 N Dunlap Suite 220
St Paul, MN 55104
(651)645-6429

ACCOUNT NUMBER

3312100

PAGE

1

CHARGES OR PAYMENTS AFTER
BILLING DATE April 15, 2003
WILL APPEAR ON NEXT STATEMENT

Audrey Berger
875 Bayard Avenue
St Paul, MN 55102

"X" payment type and enter amount paid

- ☐ CHECK
☐ VISA
☐ MASTERCARD
☐ DISCOVER

AMOUNT ENCLOSED

card number _____ valid thru ____ / ____ / ____
cardholder signature _____ date ____ / ____ / ____

ALL CHARGES ON THIS STATEMENT DUE ON PRESENTATION PLEASE RETURN
THIS PORTION OF STATEMENT WITH PAYMENT

PLEASE RETAIN THIS PORTION OF STATEMENT FOR YOUR RECORDS

DATE	DESCRIPTION	REFERENCE	CHARGES	CREDITS
03/01/03	PREVIOUS BALANCE		126 00	
04/15/03	Finance Charge	Account	1.89	
ESTIMATED INSURANCE COVERAGE 0 00				

CURRENT	30 DAYS	60 DAYS	90 DAYS	NEW BALANCE
1 89	126 00	0 00	0 00	127 89

Dale V Olson, D D S , 393 N Dunlap Suite 220, St Paul, MN 55104

PLEASE
PAY

AMOUNT DUE
127 89

STATEMENT

Dale V Olson, D D S
393 N Dunlap Suite 220
St Paul, MN 55104
(651)645-6429

ACCOUNT NUMBER

3312100

PAGE

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CHARGES OR PAYMENTS AFTER
BILLING DATE February 18, 2003
WILL APPEAR ON NEXT STATEMENT

Audrey Berger
875 Bayard Avenue
St Paul, MN 55102

"X" payment type and enter amount paid

- ☐ CHECK
☐ VISA
☐ MASTERCARD
☐ DISCOVER

AMOUNT ENCLOSED

card number	valid thru
cardholder signature	date / /

ALL CHARGES ON THIS STATEMENT DUE ON PRESENTATION PLEASE RETURN
THIS PORTION OF STATEMENT WITH PAYMENT

PLEASE RETAIN THIS PORTION OF STATEMENT FOR YOUR RECORDS

DATE	DESCRIPTION	REFERENCE	CHARGES	CREDITS
02/17/03	Oral Examination	Audrey	55 00	
02/17/03	Panoramic Film	Audrey	71 00	
ESTIMATED INSURANCE COVERAGE 0.00				

CURRENT	30 DAYS	60 DAYS	90 DAYS	NEW BALANCE
126 00	0 00	0.00	0 00	126.00

PLEASE
PAY

AMOUNT DUE
126 00

Dale V Olson, D D S , 393 N Dunlap Suite 220, St Paul, MN 55104

Teresa Allen
Claims Representative
Fleming Dedicated Claims Unit

ESIS

Post Office Box 154409
Irving TX 75015-4409
1-800 261-2762 ext 7519

March 19, 2003

Audrey Berger
875 Bayard Avenue
St Paul, MN 55102

Re	Claim Number	9489-220-986308-4
	Date of Incident	2/17/03
	Our Insured	Rainbow Foods #11
	Customer	Audrey Berger

Dear Mrs Berger

This letter follows the telephone conversation with you on today We are very sorry about your accident while shopping at Rainbow Foods on the above-mentioned date and wish you a very speedy recovery

As explained, it was determined that Rainbow was not responsible for your accident However, we will assist you with reimbursement for dental treatment needed from this accident This offer should in no way be construed as an admission of liability and is simply offered to you as customer service

Please keep any bills for treatment received and once you have completed all the necessary treatment needed, you will need to forward those to me for payment consideration I can be reached at 1-800-261-2762 extension 7519, if you have any questions

Sincerely,


Teresa Allen