

Fill in this information to identify the case:Debtor 1 KLS Acquisition Corp.

Debtor 2

(Spouse, if filing)

United States Bankruptcy Court Northern District of IllinoisCase number: 18-30052

FILED

U.S. Bankruptcy Court
Northern District of Illinois

1/12/2019

Jeffrey P. Allsteadt, 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>Harry Hulbert</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>Harry Hulbert</u> Name 2114 Park View Ct. Waukesha, WI 53188	Where should payments to the creditor be sent? (if different) _____ Name Contact phone <u>262-549-3780</u> Contact phone _____ Contact email <u>hjmshulbert@aol.com</u> Contact email _____ Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____
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 _____ <div style="text-align: right;">MM / DD / YYYY</div>	
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?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: _____						
7. How much is the claim?	\$ 460.00 <div style="float: right; text-align: right;"> 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>						
8. What is the basis of the claim?	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. unpaid medical bill– They took out deduction for insurance but did not pay the bill _____						
9. Is all or part of the claim secured?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. The claim is secured by a lien on property. 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: _____ Basis for perfection: _____ 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.) <table style="width: 100%;"> <tr> <td style="width: 50%;">Value of property:</td> <td style="width: 50%;">\$ _____</td> </tr> <tr> <td>Amount of the claim that is secured:</td> <td>\$ _____</td> </tr> <tr> <td>Amount of the claim that is unsecured:</td> <td>\$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)</td> </tr> </table> Amount necessary to cure any default as of the date of the petition: \$ _____ Annual Interest Rate (when case was filed) _____ % <input type="checkbox"/> Fixed <input type="checkbox"/> Variable	Value of property:	\$ _____	Amount of the claim that is secured:	\$ _____	Amount of the claim that is unsecured:	\$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)
Value of property:	\$ _____						
Amount of the claim that is secured:	\$ _____						
Amount of the claim that is unsecured:	\$ _____ (The sum of the secured and unsecured amounts should match the amount in line 7.)						
10. Is this claim based on a lease?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Amount necessary to cure any default as of the date of the petition. \$ _____						
11. Is this claim subject to a right of setoff?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Identify the property: _____						

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?	<input type="checkbox"/> No <input checked="" type="checkbox"/> Yes. Check all that apply.	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 checked="" 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).	\$ 460.00
	<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 4/1/19 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 1/12/2019
MM / DD / YYYY

/s/ Harry Donald Hulbert

Signature

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

Name Harry Donald Hulbert

First name Middle name Last name

Title _____

Company _____

Identify the corporate servicer as the company if the authorized agent is a servicer

Address 2114 Park View Ct.

Number Street

Waukesha, WI 53188-4770

City State ZIP Code

Contact phone 262-549-3780 Email hjmshulbert@aol.com

Note: This information is only for viewing. It cannot be used instead of a claim.

Account: 1298576-HULBERT,HARRY D

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CHATTANOOGA, TN 37422

1. MEDICARE		MEDICAID		TRICARE		CHAMPVA		GROUP HEALTH PLAN		FECA BLK LUNG		OTHER		1a. Insured's I.D. Number		(For Program in Item 1)							
(Medicare#)		(Medicaid#)		(ID#/DoD#)		(Member ID#)		(ID#)		<input checked="" type="checkbox"/> (ID#)				P89959423									
2. Patient's Name (Last Name, First Name, Middle Initial) HULBERT, HARRY, D								3. Patient's Birth Date 08 26 1954				Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>		4. Insured's Name (Last Name, First Name, Middle Initial) SAME									
5. Patient's Address (No., Street) 2114 PARKVIEW CT								6. Patient Relationship to Insured Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. Insured's Address (No., Street)											
City WAUKESHA				State WI				8. Reserved For NUCC Use				City				State							
Zip Code 53188				Telephone (Include Area Code) 262 549-3780								Zip Code				Telephone (Include Area Code)							
9. Other Insured's Name (Last Name, First Name, Middle Initial)								10. Is Patient's Condition Related To:				11. Insured's Policy Group or FECA Number PA011											
a. Other Insured's Policy or Group Number								a. Employment? (Current or Previous) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				a. Insured's Date of Birth				Sex M <input type="checkbox"/> F <input type="checkbox"/>							
b. Reserved For NUCC Use								b. Auto Accident? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				b. Other Claim ID (Designated by NUCC)											
c. Reserved For NUCC Use								c. Other Accident? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				c. Insurance Plan Name or Program Name CIGNA											
d. Insurance Plan Name or Program Name								10d. Claim Codes (Designated by NUCC)				d. Is there another Health Benefit Plan? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, complete items 9, 9a, and 9d.											
12. Patient's or Authorized Person's Signature SIGNED: <u>SIGNATURE ON FILE</u>								DATE: <u>10 24 2018</u>				13. Insured's or Authorized Person's Signature SIGNED: <u>SIGNATURE ON FILE</u>											
14. Date of Current Illness, Injury, or Pregnancy (LMP) Qual :								15. Other Date Qual :				16. Dates Patient Unable to Work in Current Occupation From To											
17. Name of Referring Physician or Other Source DR. SCHELLINGER, ROBERT E								17a. NPI 1558433409				18. Hospitalization Dates Related to Current Services From To											
19. Additional Claim Information (Designated by NUCC)												20. Outside Lab? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				\$ Charges 000							
21. Diagnosis or Nature of Illness or Injury. Relate A-L to service line below (24E) A. H40053 B. H25013 C. H43813 D. ICD Ind. 0 E. F. G. H. I. J. K. L.												22. Resubmission Code				Original Ref. No.							
23. Prior Authorization Number																							
24. A		B		C		D		E		F		G		H		I		J					
Date(s) of Service		Place of Service		EMG		Procedures, Services, or Supplies (Explain Unusual Circumstances)		Diagnosis Pointer		\$ Charges		Days or Units		EPSDT Family Plan		ID QUAL		Rendering Provider ID #					
From To		Service				CPT/HCPCS Modifier																	
10 24 18		11				92015		A		35.00		1				ZZ NPI		207W00000X 1831156835					
10 24 18		11				92083		A		150.00		1				ZZ NPI		207W00000X 1831156835					
10 24 18		11				92133		A		150.00		1				ZZ NPI		207W00000X 1831156835					
10 24 18		11				99213		ABC		125.00		1				ZZ NPI		207W00000X 1831156835					
																NPI							
																NPI							
25. Federal Tax I.D. Number 391101335				SSN X		EIN X		26. Patient's Account No. 261P101165690		27. Accept Assignment? X Yes No		28. Total Charge 460.00		29. Amount Paid 0.00		30. Rsvd for NUCC Use							
31. Signature of Physician or Supplier Including Degrees or Credentials CAROLYN P BUTLER Signed 10 29 2018 Date								32. Service Facility Location Information CC MED EYE ASSOC MUK 400 BAY VIEW DR STE D MUKWONAGO, WI 53149-1770 a. b.								33. Billing Provider Info and Ph # MEDICAL EYE ASSOCIATES SC 1111 DELAFIELD ST STE 312 WAUKESHA, WI 53188-3407 a. 1023066636 b.							

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Northern District of Illinois Claims Register

[18-30052 KLS Acquisition Corp.](#)

Honorable Judge: Jacqueline P. Cox

Chapter: 11

Office: Eastern Division

Last Date to file claims:

Trustee:

Last Date to file (Govt):

Creditor: (27417560)

Claim No: 45

Status:

Harry Hulbert

Original Filed

Filed by: CR

2114 Park View Ct.

Date: 01/12/2019

Entered by: EPoc ADI

Waukesha, WI 53188

Original Entered

Modified:

Date: 01/12/2019

Amount claimed: \$460.00

Priority claimed: \$460.00

History:

[Details](#) [45-1](#) 01/12/2019 Claim #45 filed by Harry Hulbert, Amount claimed: \$460.00 (ADI, EPoc)

Description:

Remarks:

Claims Register Summary

Case Name: KLS Acquisition Corp.

Case Number: 18-30052

Chapter: 11

Date Filed: 10/25/2018

Total Number Of Claims: 1

Total Amount Claimed*	\$460.00
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	\$460.00	
Administrative		