FORM B10 (Official Form 10) (4/01)

UNITED STATES BANKRUPTCY COURT Northern DISTRICT OF Illinois	PROOF OF CLAIM

Name of Debtor: K-MART Corporation

Case Number: 02-02474

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.

Name of Creditor (The person or other entity to whom the debtor owes money or property):

Geraldine Hand

Name and address where notices should be sent:

Rt. #1 Box 84
Dodd City, TX 75438

Telephone number: (903) 583-7570

☐ 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 box if you have never received any notices from the bankruptcy court in this case.

☐ Check box if the address differs from the address on the envelope sent to you by the court.

THIS SPACE IS FOR COURT USE ONLY

Account or other number by which creditor identifies debtor:

File # 20020103126

Check here if this claim ☐ replaces ☐ amends a previously filed claim, dated:________

1. Basis for Claim

- ☐ Goods sold
- ☐ Services performed
- ☐ Money loaned
- ☒ Personal injury/wrongful death
- ☐ Taxes
- ☐ Other ________
- ☐ Retiree benefits as defined in 11 U.S.C. § 1114(a)
- ☐ Wages, salaries, and compensation (fill out below)

Your SS #: ____ ____ ____

Unpaid compensation for services performed

from ________ (date) to ________ (date)

2. Date debt was incurred: 01-08-2002

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ 920.25

If all or part of your claim is secured or entitled to priority, also complete Item 5 or 6 below.

☐ 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.

☐ Check this box if your claim is secured by collateral (including a right of setoff).

Brief Description of Collateral:

☐ Real Estate ☐ Motor Vehicle
☐ Other________

Value of Collateral: $________

Amount of arrearage and other charges at time case filed included in secured claim, if any: $________

6. Unsecured Priority Claim.

☐ Check this box if you have an unsecured priority claim

Amount entitled to priority $________

Specify the priority of the claim:

- ☐ 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).
- ☐ Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(4).
- ☐ 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).
- ☐ Alimony, maintenance, or support owed to a spouse, former spouse, or child - 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 4/1/04 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.

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: *Attach copies of supporting documents,* 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 the filing of your claim, enclose a stamped, self-addressed envelope and copy of this proof of claim.

THIS SPACE IS FOR COURT USE ONLY

RECEIVED
TRUMBULL SERVICES
COMPANY
3-8-02
2002 MAR -8 AM 9:42
BANKRUPTCY
417 SM

Date: 2/28/02

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):

Geraldine Hand

Penalty for presenting fraudulent claim: Fine of up to $500,000 or imprisonment for up to 5 years, or both. 18 U.S.C. §§ 152 and 3571.

MAKE CHECKS PAYABLE TO:

SHERMAN RADIOLOGY ASSOCIATES
123 N CROCKETT ST STE 400
SHERMAN TX 75090-5994

Forwarding Service Requested

SHOW AMOUNT PAID HERE $

STATEMENT

Phone No: 903-892-1131

ACCOUNT NO.	STATEMENT DATE	PAY THIS AMOUNT
01-02-50515563	02/05/02	80.00

Tax Id: 75-1311913
PAGE - 1

Regardless of insurance coverag you are responsible for this bill.

SHERMAN RADIOLOGY ASSOCIATES
123 N CROCKETT ST STE 400
SHERMAN TX 75090-5994

*************AUTO**3-DIGIT 754
00003868 1 AT 0.269 01
GERALDINE HAND
RR 1 BOX 84
DODD CITY TX 75438-9704

1-10-00-0- -0- - -C-00000-00000-100-0

☐ Check box if your address is incorrect or insurance information has changed. Indicate change(s) on reverse side.

If payment has been sent, please disregard this notic

RETAIN THIS PORTION OF STATEMENT FOR YOUR TAX RECORDS.

DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

ACCOUNT NO	STATEMENT DATE	PATIENT PHONE NO.	PATIENT
01-02-50515563	02/05/02	903/583-7570	HAND, GERALDINE

DATE	*	PROCEDURE CODE	DESCRIPTION	DX CODE	AMOUNT
01/08/02	2	72050-26	SPINE,CERVICAL MIN. 4 VIEWS	723.1	40.00
01/08/02	2	72110-26	SPINE,LUMBOSACRAL,COMP W/OBLS	724.2	40.00

REFERRING PHYSICIAN	DATE ADMITTED	DATE DISCHARGED	PHYSICIAN PERFORMING SERVICE	BALANCE DU
MCBRIDE, ALAN M D			FREY, WILLIAM B M.D.	80.00

PLACE OF SERVICE: WILSON N JONES NORTH, 1111 GALLAGHER RD. SHERMAN TX 75090

*PLACE OF SERVICE
1. INPATIENT HOSPITAL
2. OUTPATIENT HOSPITAL
3. INDEPENDENT LAB
4. EMERGENCY ROOM
5. OFFICE
6. NURSING HOME
7. OTHER

DATE OF BIRTH	INJURY DATE
02/05/31	

EMPLOYER ➤
PRIMARY INSURANCE ➤
SECONDARY INSURANCE ➤

NOTE IF YOU HAVE INSURANCE, PLEASE COMPLETE INSURANCE COPY OF THIS STATEMENT AND RETURN TO OUR OFFICE.

400 East Anderson Lane Suite 300 Austin, Texas 78752
P.O. Box 16468 Austin, Texas 78761
FOR INQUIRIES PLEASE CALL
LOCAL : 512-719-7580
TOLL FREE : 1-800-880-2056

January 23, 2002

ACCOUNT IDENTIFICATION

Re: Wilson N. Jones Med Ctr North
Desk Number : 283
Account Number : 7848057
Client Number : 50515563
Date of Service : 01-08-02
Balance Due : $840.25

PERSONAL AND CONFIDENTIAL
Geraldine Hand
RT 1 Box 84
Dodd City, TX 75438-9704

Responsible Party: Hand,Geraldine

We have requested the assistance of Patient Accounts Billing Office to provide follow-up on a large number of our patient's accounts. Patient Accounts Billing Office personnel have considerable experience in working with our patients in resolving insurance and/or patient portion balances. They will periodically communicate with you as to the status of your account. Any assistance you can provide that may expedite resolution will be appreciated. Please feel free to contact Patient Accounts Billing Office at 1-800-880-2056 should you have any questions or concerns. We are confident they will be most helpful.

--- Detach and Return with Payment ---

P.O. Box 16468
Austin, TX 78761

Return Service Requested

Re: Wilson N. Jones Med Ctr North
Desk Number : 283
Account Number : 7848057
Client Number : 50515563
Date of Service : 01-08-02
Balance Due : $840.25
Amount Enclosed : ______________

PERSONAL & CONFIDENTIAL
S000010308 04 T000000041
Geraldine Hand
RT 1 Box 84
Dodd City, TX 75438-9704

Patient Accounts Billing Office
P.O. Box 16468
Austin, TX 78761-6468

(BAH

04-010308-023-STYB-067200-BAH -Y-1

TO BE COMPLETED BY STORE PERSONNEL

STORE STAMP

STORE AUTHORIZATION FOR FIRST AID

To: ______ (Name of Doctor, Clinic or Hospital)

Authorized By: [signature]

We will pay the reasonable and ordinary charges for one time emergency first aid treatment of the patient described below, administered within 24 hours of the incident described below, if this form is completed in its entirety, including the Medical Report section below, and this completed form is returned to the store with an itemized bill and a copy of the admitting notes. This authorization is for first aid only, and does not extend to follow-up care and is not an admission of liability.

Patient Name: Geraldine Hand Incident Date: 1/7/02 Incident Time: 2:45

Address: RR1 Box 84 DOB: ______ Soc. Sec. No.: 259-44-1790

Dodd City (City) TX (State) 75438 (Zip Code) Height: 5'3½ Weight: 195

Patient's Employer: Retired

TO BE COMPLETED BY PATIENT

PATIENT AUTHORIZATION TO RELEASE INFORMATION

To: **Any and all providers of medical services:** This authorization or a copy of this authorization will allow you to give to the above-described store or its representative any information you have regarding my medical history, physical, clinical or laboratory findings, diagnosis, treatment, prognosis and related information.

Patient Signature ______ Date ______
(Parent should sign for patient under age 18 and print child's name next to parent's signature.)

TO BE COMPLETED BY PHYSICIAN

PHYSICIAN'S MEDICAL REPORT

Date of examination / treatment: 1/8/2

History of incident given by patient: fell entering K-mart Sherman 1/7/2 on ice
↑ LBP + neck pain

Patient's complaints: LBP / neck pain

Clinical findings: tender neck + lumbar area

Has patient ever had same or similar condition: yes If yes, when? ongoing

Diagnosis: LBP / DDD

Treatment rendered: sees Dr [illegible] Bangerter – has had epidural injections

Prognosis: Is patient disabled? no If yes, how long is disability expected? ______

Have you treated this patient before? yes Approximate date of last treatment: 9/25/1

Signature of physician: [signature] Date: 1/8/2

Name of physician: Alan McBride Fed ID: ______

Office address: 3305 Calais Sherman TX 75090

MOSS & COX

ATTORNEYS AND COUNSELORS AT LAW

JOE D. MOSS

518 N. MAIN STREET
BONHAM, TEXAS 75418

SHARRON L. COX

PH. (903) 583-3101
FAX (903) 640-0103

March 4, 2002

K-Mart Corporation
C/o Trumbull Services
P. O. Box 426
Windsor, Connecticut 06095

Re: K-Mart Corporation Chapter 11 Bankruptcy
No. 02-02474
Northern District of Illinois

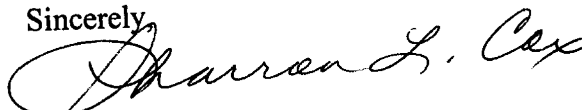
Gentlemen:

Enclosed herewith please find Proof of Claim form executed by Geraldine Hand in five copies. Please file the original and return the unused copies to me for my file.

Mrs. Hand fell on the parking lot at the K-Mart store in Sherman, Texas, and her claim is for medical bills for her injuries sustained.

Thank you for your assistance in this matter.

Sincerely,



SHARRON L. COX

Enc.

cc: Mrs. Geraldine hand
Route #1, Box 84
Dodd City, Texas 75438