UNITED STATES BANKRUPTCY COURT
NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

PROOF OF CLAIM
Chapter 11

In Re Kmart Corporation, et al.	Case Numbers 02-02462 through 02-02499
Name of Debtor: (see attached for complete list of debtors) KMART Corp.	**Case Number:**

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):

11 2367966

CROSBY, KATHERINE
2312 KILBIRNIE DR.
GERMANTOWN, TN 38139

- ☐ 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.

Your claim is scheduled as follows:

Class

UNSECURED NON PRIORITY

Amount

CONTINGENT, DISPUTED, UNLIQUIDATED

If address differs from above, please complete the following:
Creditor Name:
Telephone: #
Address:
City/St/Zip:

10077546

This Space is for Court Use Only

Account or other number by which creditor identifies debtor:

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: 1-06-02

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ 4,681.80
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)(__).

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. X Atch #1

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
CL 4885

4-12-02

Date	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):
April-2002	Katherine A. Crosby Katherine A. Crosby

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.

Atch #2 Medical Report
Atch #3 KMart incident report
Atch 4 Hospital Admission
Atch 5 KMart Ltr. Feb 2, 2002

Medical Costs relating to [illegible]
KMART Store, Germantown Parkway, Memphis, Tennessee.
Security and other employees furnished a form
to present to emergency room for KMART
to pay for treatment which has not happened.

Methodist Hospital Emergency services	1/06/02	$1,168.80
Methodist Hospital High Security Charge	1/06/02	185.00
Memphis Radiological P.C. Brain CT	1/06/02	183.00
Dr. Mark P. Clemons M.D. Ent examination	1/11/02	145.00

Attachment #1 Katherine A. Crosby

Methodist Hospital of Memphis Emergency Department

Aftercare Instructions

For **KATHERINE CROSBY, Unit #: 18006519**
(Billing #: 74431940006) 01/06/2002, 20:13

Methodist Hospital Germantown, 7691 Poplar Avenue, (901)757-6970

IMPORTANT: We have examined and treated you today on an emergency basis only. This is not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. It is impossible to recognize and treat all injuries or illnesses in a single Emergency Department visit. If you had special tests such as EKG's and X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. After leaving, you should **FOLLOW THE INSTRUCTIONS BELOW.**

You were treated today by JOHN BILLS,MD.

CONTUSIONS (Bruises).
Contusions are an injury to a body part caused by a blunt object. The force of the injury breaks some of the tiny blood vessels in and under the skin. Leaking blood from these broken vessels causes the swelling and the blue color. As the bruise heals, the swelling will go away. The bruise will change as the blood is washed away from the inside. Its color will change from blue to yellow-green and later to a faint brown. It should disappear completely in about 3 weeks.

Do the following:
- Apply ice packs. These help keep the swelling down in the first 2 days after an injury. After that, it should get steadily better.
- After 2 days, use warm packs. That will help the injury heal faster.

Call your doctor if you have:
- increased pain or swelling.
- fever.
- pain lasting longer than 1 week.
- any new or severe symptoms.

ABRASIONS.
Your scrape should heal quickly. It may be more likely to get infected.

Do the following:
- Clean the wound daily with soap and water.
- Wash your hands before and after touching the wound.
- Put a thin layer of the antibiotic ointment on it to help

Aftcltf2

healing.
- Keep the area open to the air.

Call your doctor if you have:
- increased redness, swelling or pain.
- pus, drainage or red streaks from your wound.
- fever.
- any new or severe symptoms.

HYDROCODONE & ACETAMINOPHEN (Vicodin, Lortab).
****
Take this medicine by mouth in the following dose: 1-2 tablets every 6 hours if needed for pain.
****
This is a mixture of medicines used to relieve pain. Side effects may include: sleepiness, upset stomach or constipation (hard stools). Allergy would show up as: **rash or itching, wheezing or shortness of breath**. This medicine can be habit forming if used for a long period of time.

Follow these instructions:
- Talk to your doctor **before** taking other medicines (including over-the-counter medicines).
- Sit or stand **slowly** to avoid dizziness.
- Take this medicine **with food or milk** to avoid an upset stomach.
- Store this medicine away from heat, moisture or direct light.
- Watch for signs of dependence. They include:
  - feeling that you "cannot live without this medicine".
  - you need more of this medicine than before to get the same relief.
- Do not drink alcohol, drive or operate machinery while taking this medicine.

Call your doctor if you have:
- any sign of dependence.
- any sign of allergy.
- increased pain not helped by the pain medicine.
- any new or severe symptoms.

Kirby Pittman
Winchester

****
THESE ARE YOUR FOLLOW-UP INSTRUCTIONS!
****
Call as soon as possible to make an appointment to see Dr. CLEMONS in 5 days. You can reach Dr.MARK CLEMONS at (901)363-8400, 6616 KIRBY CENTER CV, MEMPHIS, TN 38115.
****

Methodist Hospital of Memphis Emergency Department

Aftercare Instructions

For **KATHERINE CROSBY, Unit #: 18006519**
(Billing #: 74431940006) 01/06/2002, 20:13

AS ALWAYS, YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY. Please follow the instructions above carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed. If you have problems that we have not discussed or if your symptoms worsen within 24 hours, **CALL OR VISIT YOUR DOCTOR RIGHT AWAY.** If you can't reach your doctor, return to the Emergency Department.

"I understand the instructions above, and discussed in the Emergency Department."

_____

Patient or Responsible Person

_____

Physician or Nurse

SEATBELTS.

There is no doubt that seatbelts save lives. Every day in the Emergency Department we see how people without seatbelts are more severely hurt. We always buckle-up! Please do the same!

Kmart Customer Incident Information

Store: 8818 Kmart Super Center 1245 GERMANTOWN PARKWAY CORDOVA, TN 38018

Dear Kmart Customer,

We want you to have a positive experience every time you visit our store. If you have experienced an accident or loss of any kind while visiting us, please provide the information requested below. This information will help us meet our goal of continuous improvement in the operation of our store. It will also help us in contacting you to make sure we are providing the service you expect.

Please take the white copy of this document for your records. If after leaving the store you wish to provide further information or have any questions about your incident, please call our Store Team Manager.

We are sorry you had an unpleasant experience while our guest. We look forward to serving you better in the future.

Sincerely,

Your Kmart Store Management **Store Phone Number:** 309-1379

TO BE COMPLETED BY CUSTOMER:

Customer name: Katherine A. Crosby Customer's Street Address: 2312 Kilbirnie Dr.

City: Germantown State: TN Zip: 38139 Phone: 754 3322

Customer's employer: Retired Customer's sex: F

Customer's Date of Birth: Mar 6-1931 Customer's Social Security Number: 425-58-2767

If injury to a child: Child's name: _____ Child's age: _____ Parent's name: _____

Customer's Description of Incident:

Date of incident: Jan 6-2002 Location of incident: Kmart - Germantown Pkwy

Time of incident: 4 P.M What happened? Customer fell at entrance to door where automatic door operate. May have hit store basket.

Do you wish to be contacted? _____ Date reported: Jan. 6-2002 Signature of Customer: _____

Atch #3

White copy - for Customer

code (37) 094-4699-115 Rev 2/01 25/PK

[redacted]

Methodist Healthcare

Memphis Hospitals
Brownsville Hospital
Dyersburg Hospital
Lexington Hospital
McKenzie Hospital
Fayette Hospital
Jackson Hospital
Volunteer Hospital
McNairy Hospital

7447194O METH-GTOWN
CROSBY, KATHERINE
03/06/1931 F 070Y 1000551
01723
NONE, DR
01/06/2002 ER-PAT

GENERAL CONDITIONS OF ADMISSION

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS AND FINANCIAL AGREEMENT

A. MEDICAL AND SURGICAL CONSENT: The undersigned consents to any examination (x-ray or otherwise), including but not limited to medications, infusions, transfusions of blood and blood products, anesthesia, surgical procedure or treatment (including the placement of prosthesis within a patient's body), photograph, laboratory procedures which may include the drawing/testing of blood for any communicable disease such as hepatitis or HIV, and/or services rendered the patient by members of the medical staff, their representatives and/or associates, and hospital employees. The undersigned also consents to observation of surgical, diagnostic, or other procedures by medical personnel in training or by other appropriate persons permitted by the attending practitioner and allowed by hospital or departmental policy.

B. HEALTH CARE PROVIDERS: Medical personnel, including treating physicians, who provide my care or treatment, may not be employees of the Hospital. These persons include emergency room physicians, pathologists, radiologists, anesthesiologists, anesthetists, psychologists and certain nurses and aides. **I agree that it is my responsibility to ask questions sufficient to make informed decisions based on the employment status/affiliations of my health care providers.** (The employment of private duty nurses or sitters is the responsibility of the patient.)

C. TISSUE/SPECIMEN ANALYSIS AND DISPOSAL: Should my hospital stay involve the removal of tissue or parts of my body, including fetus or afterbirth, they may be retained or disposed of by the hospital, or forwarded to appropriate diagnostic entities for review and/or analysis.

D. PERSONAL VALUABLES: It is understood that the hospital maintains a safe for money and valuables, and that the hospital will not be responsible for loss or damage to any money or property of the patient or others unless delivered to or deposited with the hospital for safekeeping and a written safekeeping receipt issued by the hospital therefor.

E. SAFETY: For reasons of safety, personal electrical items will not be used in electrically susceptible areas. Personal televisions are prohibited. Only transistor-type battery operated radios are allowed. Any electrical appliances brought in by the patient must be approved by the fire and safety manager.

F. MEDICAL INFORMATION RECEIVED: The patient, if in a condition to receive it, and if not, the undersigned representative of the patient, acknowledges that he/she has been informed concerning the need for hospital services, the purpose of the patient entering the hospital, and the planned examinations, procedures, and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained.

G. RELEASE OF INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS: The hospital, my physicians, Methodist Medical Associates, or Memphis Radiological, P.C., hereinafter referred to as hospital and "other medical providers", may disclose all or any part of the record of the patient to any person or organization which is or may be liable for or responsible for payment of any of the charges of the hospital and/or other medical providers, including, but not limited to, insurance companies, medical or hospital service companies, worker's compensation carriers, employers and welfare funds. I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare or Medicaid/TennCare claim. I hereby authorize direct payment to the above-named hospital and other medical providers of all health, hospitalization, and all other insurance benefits and assign and transfer all benefits that I am entitled to or other wise are due or payable to me or my estate from any source.

H. FINANCIAL AGREEMENT: The undersigned SEVERALLY agree, whether signing as a patient or otherwise, that in consideration of the services rendered to patient, payment of the account is guaranteed by the undersigned in accordance with the regular rates and terms of the hospital and other medical providers, and is payable to the hospital and other medical providers. While any insurance or other protection related to the account of the hospital and other medical providers may be hereby assigned to and payable directly to the hospital and other medical providers, the undersigned clearly understands that the obligation to pay the hospital and other medical providers is primarily on the patient and the undersigned, and while insurance received by the hospital and other medical providers will be applied to the patient's account, any part of the account not so paid by insurance is nevertheless owing and payable. In case of default of payment, and if these accounts should be placed in the hands of a Collector or an Attorney for collection, all collection fees, attorney fees (which shall equal one-third of any balance due), cost and other expenses will be paid by the undersigned. Notice of dishonor, demand and protest are waived. It is further agreed that due to the high cost of billing and refunding small amounts, the hospital will not bill or refund underpayments or overpayments of less than five dollars ($5.00) on final balances, except on a request of the patient or responsible party.

I. RECEIPT OF COPY OF NOTIFICATION TO MEDICARE/MEDICAID EXCLUSIONS (ON REVERSE SIDE): I certify that I have received a copy of the General and Specific Medicare Exclusions which identifies the hospital charges that **are not** covered by Medicare/Medicaid/TennCare.

The above conditions apply to all units within the hospital system and this form is valid at each hospital for the length of the admission, including any discharge and readmission to another unit or facility of hospital during hospitalization. The release of information set forth hereinabove is valid for one year from date of discharge, and the assignment of insurance benefits and financial agreement is valid and binding until final settlement of the account is received. Further, I agree that the terms of this agreement shall apply to all subsequent and future services rendered to me, my spouse, or my dependents by hospital and other medical providers unless this agreement is revoked by written notice sent certified mail prior to the subsequent date of admission.

		Date	Time
Patient's Signature (or Representative) for consent to treatment and release of information:	X Katherine A. Crosby	1/6/02	[illegible]
Responsible Policyholder's Signature for Insurance Assignments:	(1) X Katherine A. Crosby		
	(2)		
All financially responsible individuals:	(1) X Katherine A. Crosby		
	(2)		

Item No. 1395 (REV 6/01) Afch #4

Kmart Customer Incident Center
Sedgwick Claims Management Services, Inc.
P.O. Box 5058, Troy, MI 48007-5058
Phone: (248) 463-7577
Fax: (248) 463-6637

February 20, 2002

Katherine Crosby
2312 Kilbirnie Drive
Germantown, TN 38139

RE: **Our Client: Kmart Corporation**
Date of Loss: 01/06/02
Our File Number: 20020102690

Dear Claimant,

Sedgwick Claims Management Services, Inc. is the claims administrator for the Kmart Corporation. We are in receipt of your claim relative to the captioned matter. We are currently conducting an investigation in connection with your claim.

Please be advised the Kmart Corporation and its thirty-seven subsidiaries filed a Voluntary Petition, pursuant to Chapter 11 of the Bankruptcy Code, in the United States Bankruptcy Court for the Northern district of Illinois. The matter has been assigned case number 02-B02474 and is pending before Judge Susan Pierson Sonderby. Pursuant to 11 U.S.C. § 362 (a), a stay of creditor actions against the debtor automatically goes into effect with the filing of the bankruptcy petition. The automatic stay provided by section 362 prohibits "the commencement or continuation, including the issuance or employment of process, of a judicial, administrative, or other action or proceeding against the debtor…" Attached please find a copy of the Voluntary Petition.

As a result of that filing, we are precluded from negotiating or settling any claims on behalf of Kmart that arose out of incidents that occurred prior to January 22, 2002 until/unless we are authorized to do so. Such authorization may or may not be extended.

Should you have any questions, or wish to discuss this matter in any way, please do not hesitate to contact the undersigned at your convenience.

Sincerely,

L. Renwrick

LaShanda E. Renwrick
Claims Examiner

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