FORM B10 (Official Form 10) 4044727

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, Troy, MI

Case Number:

Your claim is scheduled as follows

Class

UNSECURED NON PRIORITY

Amount

CONTINGENT, DISPUTED, UNLIQUIDATED

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 2382044

WARREN, DOROTHY
200 MISSION RD
PALATKA, FL 32177

☐ 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

If address differs from above, please complete the following:

Creditor Name Same

Address

City/St/Zip

Telephone #

10089498

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: 7-26-01 - 7-28-01

3. If court judgment, date obtained:

4. Total Amount of Claim at Time Case Filed: $ 620.17

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

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

SM # 5026

4-12-02

BANKRUPTCY

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)

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

20705

BC/BS #01. 70-X
SS# 263 42 1529

GUARANTOR NAME AND ADDRESS	PATIENT NO.	PATIENT NAME	DR. NO.	DATE

DATE OF BIRTH	TELEPHONE NO.	INSURANCE CODE & DESCRIPTION	INSURANCE CERTIFICATE NUMBER

PL PROC.	CR. CD.	C-CODES

KEY COMPONENTS

HISTORY | EXAM | DECISION MAKING

✔ OFFICE/OUTPATIENT — CODE

X (checked item)

✔ MEDICARE OFFICE CONSULTATIONS — CODE — FEE

✔ HOSPITAL CONSULTATIONS — CODE — FEE

✔ EMERGENCY DEPARTMENT SERVICES — CODE — FEE

✔ PROCEDURE — CODE — FEE

✔ OFFICE VISITS MISCELLANEOUS — CODE

DIAGNOSIS

Fracture Glenoid left shoulder

SURGICAL PROCEDURE

DISABILITY STATEMENT

RETURN TO

SUPPLIES & MATERIALS

✔ sling / swathe

TOTAL DUE →

pd.

DATE OF ACCIDENT

X RAYS

RETURN

3

YOUR NEXT APPOINTMENT

DATE	DAY	TIME
[illegible]	[illegible]	9:45

20745

GUARANTOR NAME AND ADDRESS	PATIENT NO.	PATIENT NAME	DR. NO.	DATE

DATE OF BIRTH	TELEPHONE NO.	INSURANCE CODE & DESCRIPTION	CERTIFICATE NUMBER

PL PROC.	CR. CD.	C-CODES

HISTORY

✔ OFFICE/OUTPATIENT

✔ OFFICE VISITS

DIAGNOSIS

SURGICAL PROCEDURE

SUPPLIES & MATERIALS

Pd.

YOUR NEXT APPOINTMENT

DATE	DAY	TIME
11-27-01	Tuesday	9:45

20662

GUARANTOR NAME AND ADDRESS	PATIENT NO.	PATIENT NAME	DR. NO.	DATE

DATE OF BIRTH	TELEPHONE NO.	INSURANCE CODE & DESCRIPTION	CERTIFICATE NUMBER

PL PROC.	CR. CD.	C-CODES

KEY COMPONENTS

DECISION MAKING

✓ MEDICARE OFFICE CONSULTATIONS CODE FEE

CODE

FEE

FEE

CODE FEE

CODE

SUPPLIES & MATERIAL

TOTAL DUE →

Pd.

YOUR NEXT APPOINTMENT		
DATE	DAY	TIME

STATEMENT OF ACCOUNT

000765R

WARREN DOROT 000811345455054480000000146133

353

PUTNAM COMMUNITY MED CTR
PO BOX 778
PALATKA FL 32178-0778
PHONE:386-328-5711

STATEMENT DATE 03/20/02 | PAGE 1 OF 1

ACCOUNT NUMBER	PATIENT NAME	STATEMENT PERIOD	AMOUNT DUE
811345455	WARREN DOROTHY E	EMERGENCY 09/26/01 TO 09/26/01	$146.13

MAIL PAYMENT TO

WARREN DOROTHY E
200 MISSION RD
PALATKA FL 32177

PUTNAM COMMUNITY MED CTR
PO BOX 778
PALATKA FL 32178-0778
PHONE:386-328-5711

I have not paid this.

TO RECEIVE PROPER CREDIT PLEASE RETURN THIS PORTION WITH YOUR PAYMENT
NOTE: SHOULD YOU WISH TO PAY BY CREDIT CARD, SEE AUTHORIZATION NOTICE ON THE BACK.

STATEMENT OF ACCOUNT

000765L

WARREN DOROT 000811350456054480000000054137

354

PUTNAM COMMUNITY MED CTR
PO BOX 778
PALATKA FL 32178-0778
PHONE:386-328-5711

STATEMENT DATE 03/20/02 | PAGE 1 OF 1

ACCOUNT NUMBER	PATIENT NAME	STATEMENT PERIOD	AMOUNT DUE
811350456	WARREN DOROTHY E	EMERGENCY 09/28/01 TO 09/28/01	$54.13

MAIL PAYMENT TO

WARREN DOROTHY E
200 MISSION RD
PALATKA FL 32177

PUTNAM COMMUNITY MED CTR
PO BOX 778
PALATKA FL 32178-0778
PHONE:386-328-5711

I have not paid this.

TO RECEIVE PROPER CREDIT PLEASE RETURN THIS PORTION WITH YOUR PAYMENT
NOTE: SHOULD YOU WISH TO PAY BY CREDIT CARD, SEE AUTHORIZATION NOTICE ON THE BACK.

Medicare Summary Notice

January 2, 2002
FI -NI 088064

DOROTHY E WARREN
200 MISSION RD
PALATKA FL 32177

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 303-28-0794A

If you have questions,write or call.
Medicare Part B
P O Box 2360
Jacksonville, FL 32231

Toll-free: 1-800-333-7586
TTY for Hearing Impaired: 1-800-754-7820

HELP STOP FRAUD: Do not sell your Medicare Number or Medicare Summary Notice

This is a summary of claims processed on 12/04/2001.

PART B MEDICAL INSURANCE - ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim number 51-1327-08119-00						
PUTNAM DIAG IMAGING CTR LLC, 6905 OLD WOLF BAY RD, PALATKA FL 32177-6801						
Referred by H PASCHALL, M.D						
11 19 01	1 X-ray exam of shoulder (73030-LT)	$75.00	$32.25	$25.80	$6.45	
11 19 01	1 X-ray exam of elbow (73080-LT)	75.00	31.87	25.50	6.37	
Claim Total		**$150.00**	**$64.12**	**$51.30**	**$12.82**	

Deductible Information:

I was billed, and I paid the $12.82

You have met the Part B deductible for 2001.

THIS IS NOT A BILL - Keep this notice for your records.