UNITED STATES BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA
JACKSONVILLE DIVISION

PROOF OF CLAIM

YOUR CLAIM IS SCHEDULED AS:
Schedule/Claim ID s4699
Amount/Classification
$65.60 Priority

In re:
TAYLOR, BEAN & WHITAKER MORTGAGE CORP.

Case Number:
3:09-bk-07047-JAF

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.

☐ 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.

Name of Creditor and Address: the person or other entity to whom the debtor owes money or property
If necessary, please cross out pre-printed address and write in change of address.

2183692900164

HOLDAWAY, CYNTHIA L
6307 PECAN COURSE
OCALA, FL 34472

CLAIM FILED
JACKSONVILLE, FLORIDA
MAR 11 2010
CLERK, U.S. BANKRUPTCY COURT
MIDDLE DISTRICT OF FLORIDA

Creditor Telephone Number (352)687-4726 ☑ Check box if address is new. Notice is to be sent.

The amount(s) 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 "CUD", 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.

Name and address where **payment** should be sent (if different from above):

Payment Telephone Number ( )

☐ Check this box if you are the debtor or trustee in this case.

☐ Check this box to indicate that this claim amends a previously filed claim.
Claim Number (if known):
Filed on: _____

1. AMOUNT OF CLAIM AS OF DATE CASE FILED $ _____
If all or part of your claim is secured, complete item 4 below; however, if all of your claim is unsecured, do not complete item 4.
If all or part of your claim is entitled to priority, complete item 5.
☐ Check this box if claim includes interest or other charges in addition to the principal amount of claim. Attach itemized statement of interest or charges.

2. BASIS FOR CLAIM: _____
(See instructions #2 and #3a on reverse side.)

3. LAST FOUR DIGITS OF ANY NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR: _____
3a. Debtor may have scheduled account as: _____

4. SECURED CLAIM (See instruction #4 on reverse side.)
Check the appropriate box if your claim is secured by a lien on property or a right of set off and provide the requested information
Nature of property or right of setoff:
Describe:
☐ Real Estate ☐ Motor Vehicle ☐ Other _____
Value of Property: $ _____ Annual Interest Rate: _____ %
Secured Claim Amount: $ _____ **DO NOT** include the priority portion of your claim here.
Unsecured Claim Amount: $ _____
Amount of arrearage and other charges as of time case filed included in secured claim, if any: $ _____ Basis for Perfection: _____

5. PRIORITY CLAIM
☐ Amount of Claim Entitled to Priority under 11 U.S.C. §507(a). If any portion of your claim falls in one of the following categories, check the box and state the amount.
Unsecured Priority Claim Amount: $ 2106.00 Include **ONLY** the priority portion of your unsecured claim here.

You MUST specify the priority of the claim:
☐ Domestic support obligations under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).
☐ Wages, salaries, or commissions (up to $10,950*), earned within 180 days before filing of the bankruptcy petition or cessation of the debtor's business, whichever is earlier - 11 U.S.C. § 507(a)(4).
☑ Contributions to an employee benefit plan - 11 U.S.C. § 507(a)(5).
☐ Up to $2,425* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use -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 4/1/10 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment.*

6. CREDITS: The amount of all payments on this claim has been credited for the purpose of making this proof of claim.

7. SUPPORTING DOCUMENTS: *Attach redacted copies of supporting documents,* such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, court judgments, mortgages, and security agreements. You may also attach a summary. Attach redacted copies of evidence of perfection of a security interest. (See definition of "redacted" on reverse side.)
If the documents are not available, please explain.

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.
DO NOT SEND ORIGINAL DOCUMENTS. ATTACHED DOCUMENTS MAY BE DESTROYED AFTER SCANNING.

The original of this completed proof of claim form must be sent by mail, hand, courier or overnight delivery (facsimile, telecopy or other electronic means NOT accepted), so that it is actually received on or before 5:00 p.m. prevailing Eastern Time on June 15, 2010, the Bar Date (as defined in the Bar Date Notice).

THIS SPACE FOR COURT USE ONLY
T, B & W Mortgage Corp.
01138

By Regular Mail to:
BMC Group, Inc.
Attn: Taylor, Bean & Whitaker Mortgage Corp. Claim Processing
PO Box 3020
Chanhassen, MN 55317-3020

By Hand, Courier, Or Overnight Delivery to:
BMC Group, Inc.
Attn: Taylor, Bean & Whitaker Mortgage Corp. Claim Processing
18750 Lake Drive East
Chanhassen, MN 55317

DATE 3/10/10

SIGNATURE: The person filing this claim must sign it. Sign and print name and title, if any, of the creditor or other person authorized to file this claim and state address and telephone number if different from the notice address above. Attach copy of power of attorney, if any.
Cynthia Holdaway CYNTHIA HOLDAWAY

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.

INSTRUCTIONS FOR PROOF OF CLAIM FORM

The instructions and definitions below are general explanations of the law. In certain circumstances, such as bankruptcy cases not filed voluntarily by the debtor, there may be exceptions to these general rules.

ITEMS TO BE COMPLETED IN PROOF OF CLAIM FORM (IF NOT ALREADY PROPERLY FILLED IN)

Court, Name of Debtor, and Case Number:
Use this proof of claim form only if you are asserting a claim against the Debtor, Taylor, Bean & Whitaker Mortgage Corp. If you received a notice of the case from the Claims Agent, BMC Group, some or all of this information may have been already completed.

DEBTOR	CASE NO	PETITION DATE
Taylor, Bean & Whitaker Mortgage Corp.	3:09-bk-07047-JAF	8/24/2009

Creditor's Name and Address:
Fill in the name of the person or entity asserting a claim and the name and address of the person who should receive notices issued during the bankruptcy case. A separate space is provided for the payment address if it differs from the notice address. The creditor has a continuing obligation to keep the court informed of its current address. See Federal Rule of Bankruptcy Procedure (FRBP) 2002(g).

1. Amount of Claim as of Date Case Filed:
State the total amount (in lawful US currency) owed to the creditor on the date of the Bankruptcy filing. Follow the instructions concerning whether to complete item 4. Check the box if interest or other charges are included in the claim.

2. Basis for Claim:
State the type of debt or how it was incurred. Examples include goods sold, money loaned, services performed, personal injury/wrongful death, car loan, mortgage note, and credit card.

3. Last Four Digits of Any Number by Which Creditor Identifies Debtor:
State only the last four digits of the debtor's account or other number used by the creditor to identify the debtor.

3a. Debtor May Have Scheduled Account As:
Use this space to report a change in the creditor's name, a transferred claim, or any other information that clarifies a difference between this proof of claim and the claim as scheduled by the debtor.

4. Secured Claim:
Check the appropriate box and provide the requested information if the claim is fully or partially secured. Skip this section if the claim is entirely unsecured. (See DEFINITIONS, below.)
State the type and the value of property that secures the claim, attach copies of lien documentation, and state annual interest rate and the amount past due on the claim as of the date of the bankruptcy filing.

5. Amount of Claim Entitled to Priority Under 11 U.S.C. §507(a).
If any portion of your claim falls in one or more of the listed categories, check the appropriate box(es) and state the amount entitled to priority. (See DEFINITIONS, below.) A claim may be partly priority and partly non-priority. For example, in some of the categories, the law limits the amount entitled to priority.

6. Credits:
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.

7. Supporting Documents:
Attach to this proof of claim form redacted copies documenting the existence of the debt and of any lien securing the debt. You may also attach a summary if documentation is voluminous or an explanation if documentation is not available. You must also attach copies of documents that evidence perfection of any security interest. You may also attach a summary. FRBP 3001(c) and (d).
Do not send original documents, as attachments may be destroyed after scanning.

Date and Signature:
The person filing this proof of claim must sign and date it. FRBP 9011. Print the name and title, if any, of the creditor or other person authorized to file this claim. State the filer's address and telephone number if it differs from the address given on the top of the form for purposes of receiving notices. Attach a complete copy of any power of attorney. Criminal penalties apply for making a false statement on a proof of claim.

Date-Stamped Copy:
Return claim form and attachments. If you wish to receive an acknowledgement of your claim, please enclose a self-addressed stamped envelope and a second copy of the proof of claim form with any attachments to the Claims Agent, BMC Group, at the address on the front of this form.

Please read – important information: upon completion of this claim form, you are certifying that the statements herein are true.

Be sure all items are answered on the claim form. If not applicable, insert "Not Applicable."

DEFINITIONS

DEBTOR
A debtor is the person, corporation, or other entity that has filed a bankruptcy case.

CREDITOR
A creditor is any person, corporation, or other entity to whom the debtor owed a debt on the date that the bankruptcy case was filed.

CLAIM
A claim is the creditor's right to receive payment on a debt that was owed by the debtor on the date of the bankruptcy filing. See 11 U.S.C. §101 (5). A claim may be secured or unsecured.

PROOF OF CLAIM
A form telling the bankruptcy court how much the debtor owed a creditor at the time the bankruptcy case was filed (the amount of the creditor's claim). This form must be filed with the court-appointed Claims Agent, BMC Group, at the address listed on the reverse side of this page

SECURED CLAIM Under 11 U.S.C. §506(a)
A secured claim is one backed by a lien on property of the debtor. The claim is secured so long as the creditor has the right to be paid from the property prior to other creditors.
The amount of the secured claim cannot exceed the value of the property. Any amount owed to the creditor in excess of the value of the property is an unsecured claim Examples of liens on property include a mortgage on real estate or a security interest in a car.
A lien may be voluntarily granted by a debtor or may be obtained through a court proceeding. In some states, a court judgment is a lien. A claim also may be secured if the creditor owes the debtor money (has a right to setoff).

UNSECURED NONPRIORITY CLAIM
If a claim is not a secured claim it is an unsecured claim. A claim may be partly secured and partly unsecured if the property on which a creditor has a lien is not worth enough to pay the creditor in full.

UNSECURED PRIORITY CLAIM Under 11 U.S.C. §507(a)
Priority claims are certain categories of unsecured claims that are paid from the available money or property in a bankruptcy case before other unsecured claims.

Evidence of Perfection
Evidence of perfection may include a mortgage, lien, certificate of title, financing statement, or other document showing that the lien has been filed or recorded.

INFORMATION

Redacted
A document has been redacted when the person filing it has masked, edited out, or otherwise deleted, certain information. A creditor should redact and use only the last four digits of any social-security, individual's tax-identification, or financial-account number, all but the initials of a minor's name and only the year of any person's date of birth.

Offers to Purchase a Claim
Certain entities are in the business of purchasing claims for an amount less than the face value of the claims. One or more of these entities may contact the creditor and offer to purchase the claim. Some of the written communications from these entities may easily be confused with official court documentation or communications from the debtor. These entities do not represent the bankruptcy court or the debtor. The creditor has no obligation to sell its claim. However, if the creditor decides to sell its claim, any transfer of such claim is subject to FRBP 3001(e), any applicable provisions of the Bankruptcy Code (11 U.S.C. § 101 et seq.), and any applicable orders of the bankruptcy court.

ONCE YOUR CLAIM IS FILED YOU CAN OBTAIN OR VERIFY YOUR CLAIM NUMBER BY VISITING www.bmcgroup.com/tbwmortgage

Taylor, Bean
& Whitaker
Mortgage Corporation
315 NE 14th Street
Ocala, FL 34470

June 29, 2009

Cynthia Holdaway
6307 Pecan Course
Ocala, FL 34472

Dear Cynthia:

This letter is to inform you that Taylor, Bean & Whitaker has received your "Certification of Health Care Provider" form, which verifies your eligibility for Family and Medical Leave (FMLA). The Family and Medical Leave Act (FMLA) requires employers to provide up to twelve (12) weeks of unpaid, job-protected leave for certain family and medical reasons. I'm enclosing a copy of our confirmed "Employer Response to Employee Request for FMLA" form.

According to the "Certification of Health Care Provider" form, your leave is scheduled to commence on **September 4th, 2009** and your estimated return to work date is **October 16th, 2009,** however your FMLA entitlement allows you 12 weeks which will conclude on **November 26th, 2009**. Should the return to work date change, please contact me as soon as possible to discuss. *You must present a return to work certification prior to your scheduled return date*. The form is enclosed.

In accordance with our FMLA policy and as permitted by FMLA regulations, if you are unable to return to work after the 12 weeks of FMLA leave have been exhausted, we must consider you to have resigned your position.

As a reminder, Taylor, Bean & Whitaker will pay all your insurance premiums while you are on leave. You would have to repay them through payroll deductions upon your return to work.

If you have any questions or would like more information regarding your leave of absence, please contact me at (352) 236-7253 or Rina Rivera at (352) 690-9413.

Regards,

Heidy M. Gonzalez
Benefits Clerk
Taylor, Bean & Whitaker
hgonzalez@taylorbean.com

Enclosures

Designation Notice (Family and Medical Leave Act)

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division

U.S. Wage and Hour Division

OMB Control Number: 1215-0181
Expires: 12/31/2011

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: Cynthia Holdaway

Date: 06/29/2009

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.
We received your most recent information on June 23rd, 2009 and decided:

✓ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:

✓ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: Delivery date 9/4/09 up to 12 weeks.

_____ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

Please be advised (check if applicable):

_____ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

_____ We are requiring you to substitute or use paid leave during your FMLA leave.

✓ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ☑ **is** ☐ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

_____ **Additional information is needed to determine if your FMLA leave request can be approved:**

_____ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____, unless it is not
(Provide at least seven calendar days)
practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____
(Specify information needed to make the certification complete and sufficient)

_____

_____ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

_____ Your FMLA Leave request is Not Approved.
_____ The FMLA does not apply to your leave request.
_____ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

JEFFERSON PILOT FINANCIAL

Jefferson Pilot Financial Insurance Company, PO Box 672408, Marietta, GA 30006-0041
Phone (877) 843-3948 Fax (800) 259-2335
www.jpfinancial.com

GROUP SHORT TERM DISABILITY

STATEMENT OF EMPLOYEE (*BENEFITS MAY BE DELAYED IF CLAIM FORM IS NOT FULLY COMPLETED)*

Please sign this page and the authorization on page two of this form to avoid delays in processing

1. Full Name **(last, first, middle initial)**	2. Social Security Number	3. Phone Number (include area code)	
Holdaway Cynthia L	546-35-3674	(352) 292-3538	
4. Street Address & Mailing Address	5. City	6. State	7. Zip Code
6307 Pecan Course	Ocala	FL	34472
8. Date of Birth	9. I have been unable to work because of my disability since	10. Gender ☐ Male ☒ Female	
7/3/72		11. Hospital Confined ☐ Yes ☒ No	
12. Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced	13. Have you ever had the same or similar condition in the past? ☐ Yes ☒ No If "Yes" provide dates:		
14. Is your disability due to a: ☐ Sickness ☐ Injury ☒ Other	14a. Please describe your Sickness or how your Injury occurred: Pregnancy	Height: 5 7	
15. I returned to work part-time on: I returned to work full-time on:		Weight: 166	

16. Is your accident or illness due to your occupation? ☐ Yes ☒ No If "Yes" explain:

Have you or do you intend to file a Workers Compensation Claim? ☐ Yes ☒ No

17. Treated by: (on another piece of paper, provide names & addresses of all doctors who have treated you for this disability).

Doctor: Dr Phillip Johnson

Address: _____

18. Describe other income you are receiving, have applied for, or will be applying for:

	Amount	Date Began	Date Will Terminate	Date Applied For
Social Security (Disability Retirement)	$_____			
Salary Continuance or State Disability Benefits	$_____			
Workers' Compensation	$_____	_____	_____	_____
Other income related to your disability	$_____	_____	_____	_____

19. The above statements are true and complete to the best of my knowledge and belief. **I have completed and attached the Authorization for Release of Information.**

Signature of Employee _____ Date _____

20. Please provide us with your e-mail address:

EMPLOYER'S REPORT OF CLAIM *(TO BE COMPLETED BY EMPLOYER)*

Please submit a copy of this employee's complete Job Description with this claim form.
Please submit a copy of this employee's enrollment statement with this claim.

1. Occupation of Employee/Claimant	2. Insurance Class 001	3. Employee Date of Hire	
4. Number of Hours Worked Per Week		5. Date Insured	
6. Date Employee was Last Present at Work	7. Employee's Basic Weekly Earnings	8. Returned to Work? ☐ Full-time ☐ Part-time Date:	
9. Percent of premium paid by: Employee: 100 % ☐ pre-tax ☒ post-tax Employer: %		10. Is the Claim due to your employee's occupation: ☐ Yes ☐ No 11. Has a Workers' Compensation claim been filed? ☐ Yes ☐ No	

12. Has Insured received any other income since the date last worked: ☐ Yes ☐ No

Please specify the type of income (Sick Pay, Vacation, Salary Continuation, Paid Time Off, Etc.)_____

Weekly Amount Paid $ Date Began: Date Ended:

Employer's Name & Address (or name of policyholder, if other)	Telephone Number (Include Area Code and Extension)	Group Policy Number & Division Number
Taylor, Bean & Whitaker 101 NE 2nd Avenue Ocala, FL 34470	(352) 690-9413	0063634 -- 280306

E-mail address rrivera@taylorbean.com Fax Number (Include Area Code) (352) 732-9413

Signature of Person Completing this Form and Title Benefits Administrator Date

ATTENDING PHYSICIAN'S STATEMENT

1. Name of Patient	2. Social Security Number	3. Employer Name
CYNTHIA HOLDAWAY	584-35-3674	TBW

4. When did symptoms first appear or accident happen?	5. Date you believe patient was unable to work?
LMP: 11/28/08	Date of delivery EDD: 9/4/09

6. Diagnosis (including complications)	7. Subjective symptoms
Birth of Child	LMP: 11/28/08

8. Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)
+ HCG, Ultrasound confirms IUP, EDD: 9/4/09

9. List of Restrictions & Limitations
postpartum recovery approx. 6 weeks

10. Nature of treatment (including surgery and medications prescribed, if any).
OB/Prenatal care until delivery, six-week postpartum exam, Rx prenatal vitamins

11. Names, specialty and addresses of other treating physicians NA

12. Has patient ever had same or similar condition? ☑ Yes ☐ No If "Yes" provide dates. 1999, 1997

13. Do you consider this condition to be due to your patient's employment? ☐ Yes ☑ No

14. If pregnancy, Estimated date of delivery: 9/4/09 Actual date of delivery:	15. Date first treated	16. Date of last visit/treatment
	1/28/09	5/21/09

17. Frequency ☐ Weekly ☑ Monthly ☐ Other (specify) until 30 wks then bi-weekly until 36 wks then weekly until delivery

18. Has patient: ☐ Recovered ☐ Improved ☑ Unchanged ☐ Regressed

19. Is patient: ☑ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined

20. Has patient been hospital confined? ☐ Yes ☑ No Confined from: to
If "Yes" give name of hospital. will be admitted to Munroe Regional at onset of labor

21. Has surgery been scheduled or performed? ☐ Yes ☑ No If "Yes" date of surgery:
Type of surgery scheduled:

22. Prognosis and Rehabilitation:
a. When do you think your patient will be able to return to work?
PRESENT occupation? 6 weeks postpartum ALL OTHER occupations? 6 weeks postpartum
b. Can present job be modified to allow patient to handle with his/her impairment? ☐ Yes ☑ No
c. **When could trial employment commence?** 6 wks postpartum ☑ Full-time ☑ Part-time
Please submit clinical documentation to support your decision.

Print Name (Attending Physician)	Specialty	Telephone (Include Area Code)
Philip N. Johnson, M.D.	OB/GYN	(352) 620-2229

Street Address/City or Town/State or Providence/Zip Code
1805 SE 16 Ave # 300 Ocala, FL. 34471

Signature (Attending Physician) No stamps please	Date	Fax Number (Include Area Code)
	6/16/09	(352) 620-8833

JEFFERSON PILOT FINANCIAL INSURANCE COMPANY IS NOT RESPONSIBLE FOR CHARGES INCURRED DUE TO COMPLETION OF THIS FORM. THE PATIENT IS RESPONSIBLE FOR ANY CHARGES ASSOCIATED WITH FORM COMPLETION.

March 8, 2010

BMC, Group, Inc.
Attn: Taylor, Bean, & Whitaker Mortgage Corp. Claims Processing
P.O. Box 3020
Chanhassen, MN. 55317-3020

To Whom It May Concern:

This letter is in reference to the Proof of Claim received by your company on March 5, 2010.

I am sending along with this letter the information showing I was approved for Short Term Disability thru Taylor, Bean & Whitaker Mortgage. I worked for TBW for almost 9 years and paid into my Short Term Disability that I never used.

During my employment at TBW I had contributed approximately $2106.00 to this insurance. Well I was 9 months pregnant with my daughter and I was approved for the short term to be paid to me. I left TBW on the 7th of August 2009, I wasn't sure how long the insurance would be extended however, come to find out TBW cut off all insurance as of the 15th of August and my daughter was delivered the 20th.

I was under the impression that due to the fact I paid into this Short Term for 9 years that I was entitled to this money. I was denied the funds by Lincoln Financial services after I was told I would be getting the funds for my 4 weeks of being out of work.

Please I am still unemployed and have been since the company closed, and this money would help out my family.

Thank you for your time

Cynthia Holdaway
PO Box 832622
Ocala Florida 34483
352-687-4126
352-286-3774

Cynthia Holdaway