UNITED STATES BANKRUPTCY COURT
FOR THE DISTRICT OF DELAWARE

PROOF OF CLAIM

In re

Women First HealthCare, Inc ,
Debtor

Case Number

04-11278 (MFW)

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 and Address

06509442001679

ROBERT E MOE
21791 LAKE FOREST DR STE 206
LAKE FOREST CA 92630 2756

Creditor Telephone Number ( ) 949 - 951-8860

☐ 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 this address differs from the address on the envelope sent to you by the court

If you have already filed a proof of claim with the Bankruptcy Court or BMC you do not need to file again

THIS SPACE IS FOR COURT USE ONLY

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR

Check here if this claim ☐ replaces or ☐ amends a previously filed claim dated _____

1 BASIS FOR CLAIM

☐ Goods sold
☒ Services performed
☐ Money loaned
☐ Personal injury/wrongful death
☐ Taxes
☐ Other (describe briefly) _____
☐ Retiree benefits as defined in 11 U S C § 1114(a)
☐ Wages salaries and compensation (Fill out below)
Last four digits of SS # _____
Unpaid compensation for services performed from _____ (date) to _____ (date)

2 DATE DEBT WAS INCURRED 2-11-2004

3 IF COURT JUDGMENT, DATE OBTAINED

4 TOTAL AMOUNT OF CLAIM AT TIME CASE FILED

$ 490.23	$ —	$ —	$ 490 23
(unsecured)	(secured)	(unsecured priority)	(Total)

If all or part of your claim is secured or entitled to priority, also complete Item 5 or 7 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 NONPRIORITY CLAIM $ 490 23

☒ Check this box if a) there is no collateral or lien securing your claim or b) your claim exceeds the value of the property securing it or if c) none or only part of your claim is entitled to priority

7 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 $4 925)* 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 $2 225* 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 4/1/07 and every 3 years thereafter with respect to cases commenced on or after the date of adjustment

8 CREDITS The amount of all payments on this claim has been credited and deducted for the purpose of making this proof of claim

9 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

10 DATE-STAMPED COPY To receive an acknowledgment of your claim, please enclose a self-addressed, stamped envelope and an additional copy of this proof of claim.

The original of this completed proof of claim form must be sent by mail or hand delivered (FAXES NOT ACCEPTED) so that it is received on or before 4 00 pm, Eastern Time on August 31, 2004

BY MAIL TO
Women First HealthCare Inc
c/o BMC Group f/k/a Bankruptcy Management Corp
PO Box 983
El Segundo CA 90245 0983

BY HAND OR OVERNIGHT DELIVERY TO
Women First HealthCare Inc
c/o BMC Group f/k/a Bankruptcy Management Corp
1330 East Franklin Ave
El Segundo CA 90245

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FILED
JUL 07 2004
BMC

Women First Healthcare Inc
00031

DATE SIGNED
7-3-2004

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)

CPA - OWNER

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

Robert E. Moe
Certified Public Accountant

February 11, 2004

Women First HealthCare, Inc
5355 Mira Sorrento Place, Suite 700
San Diego, CA 92121

Invoice for Services Rendered

Preparation of Form 5500 for the Women First HealthCare, Inc Health & Welfare Benefits Plan for the year ending April 30, 2003	$ 225 00
Preparation of Amended Form 5500 for the Women First HealthCare, Inc Health & Welfare Benefits Plan for the year ending April 30, 2002	250 00
Overnight Charge	15 23
Total Amount Due	$ 490.23

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