

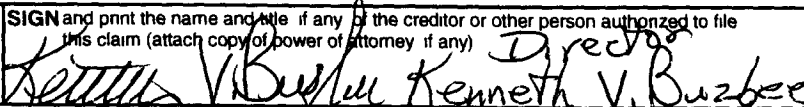


UNITED STATES BANKRUPTCY COURT FOR THE DISTRICT OF DELAWARE		PROOF OF CLAIM	
In re Women First HealthCare, Inc , Debtor		Case Number 04-11278 (MFW)	
NOTE This form should not be used to make a claim for an administrative expense arising after the commencement of the case. A request for payment of an administrative expense may be filed pursuant to 11 U.S.C. § 503.		<input type="checkbox"/> 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. <input type="checkbox"/> Check box if you have never received any notices from the bankruptcy court in this case. <input type="checkbox"/> Check box if this address differs from the address on the envelope sent to you by the court.	
Name of Creditor and Address  06509442002075 SECRETARY OF STATE ILLINOIS JESSE WHITE DEPARTMENT OF BUSINESS SERVICE SPRINGFIELD IL 62756		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	
Creditor Telephone Number () ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR F 6081-856-8			
1 BASIS FOR CLAIM <input type="checkbox"/> Goods sold <input type="checkbox"/> Personal injury/wrongful death <input type="checkbox"/> Retiree benefits as defined in 11 U.S.C. § 1114(a) <input type="checkbox"/> Services performed <input checked="" type="checkbox"/> Taxes <input type="checkbox"/> Wages, salaries and compensation (Fill out below) <input type="checkbox"/> Money loaned <input type="checkbox"/> Other (describe briefly) _____ Last four digits of SS # _____ Unpaid compensation for services performed from _____ to _____ <div style="text-align: right;">(date) (date)</div>		Check here <input type="checkbox"/> replaces or <input type="checkbox"/> amends a previously filed claim dated _____ if this claim	
2 DATE DEBT WAS INCURRED December 1, 2003		3 IF COURT JUDGMENT, DATE OBTAINED	
4 TOTAL AMOUNT OF CLAIM AT TIME CASE FILED \$ _____ (unsecured) \$ _____ (secured) \$ <u>135,311.10</u> (unsecured priority) \$ <u>135,311.10</u> (Total)			
If all or part of your claim is secured or entitled to priority, also complete item 5 or 7 below. <input checked="" type="checkbox"/> 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 <input type="checkbox"/> Check this box if your claim is secured by collateral (including a right of setoff). Brief description of collateral: <input type="checkbox"/> Real Estate <input type="checkbox"/> Motor Vehicle <input type="checkbox"/> Other _____ Value of Collateral \$ _____ Amount of arrearage and other charges at time case filed included in secured claim if any \$ _____		7 UNSECURED PRIORITY CLAIM <input checked="" type="checkbox"/> Check this box if you have an unsecured priority claim. Amount entitled to priority \$ <u>135,311.10</u> Specify the priority of the claim: <input type="checkbox"/> 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) <input type="checkbox"/> Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(4) <input type="checkbox"/> 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) <input type="checkbox"/> Alimony, maintenance or support owed to a spouse, former spouse or child. 11 U.S.C. § 507(a)(7) <input checked="" type="checkbox"/> Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8) <input type="checkbox"/> Other. Specify applicable paragraph of 11 U.S.C. § 507(a) (____). <small>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.</small>	
6 UNSECURED NONPRIORITY CLAIM \$ _____ <input type="checkbox"/> 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 c) none or only part of your claim is entitled to priority.			
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.		THIS SPACE FOR COURT USE FILED AUG 03 2004 BMC <small>Women First Healthcare Inc</small>  <small>00078</small>	
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			
DATE SIGNED 7/28/04	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).  Kenneth V. Buzbee		

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

Corporation Name Women First HealthCare, Inc

File # F 6081-856-8

Franchise Tax	\$	114,606 86
Filing Fee	\$	75 00
Penalty	\$	11,460 69
Interest	\$	<u>9,168 55</u>
Total	\$	135,311 10