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

☐ 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

Name of Creditor and Address

06509442002499

ZEE MEDICAL INC
2845 WORKMAN MILL RD
WHITTIER CA 90601 1549

Creditor Telephone Number ( )

ACCOUNT OR OTHER NUMBER BY WHICH CREDITOR IDENTIFIES DEBTOR

003993

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 1-5-04 : 1.22-04

3 IF COURT JUDGMENT, DATE OBTAINED

4 TOTAL AMOUNT OF CLAIM AT TIME CASE FILED

$ 147 85	$	$	$
(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 $ _____

☐ 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

THIS SPACE FOR COURT USE ONLY

FILED
AUG 31 2004
BMC

Women First Healthcare Inc
00153

DATE SIGNED 8-30-04

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)

Maria Eskew Co. Mgr MARIA ESKEW

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

INVOICE

ZEE MEDICAL, INC.
PO BOX 4530
CHESTERFIELD MO 63006-4530
800-491-5024

PAGE 1
DATE 01/05/2004
TIME 14:11:13

MARC SOKOLOWSKI

ATT: 32/057/65

ORDER/INVOICE# 140628128
P.O.#
TAX RATE1(T) 7.75
TAX RATE2(2) 0.00

BILL TO # 003993
WOMEN 1ST HEALTHCARE
5355 MIRA SORENTO PLACE
SAN DIEGO CA 92121-
619-509-1171

SHIP TO# 003993
WOMEN 1ST HEALTHCARE
5355 MIRA SORENTO PLACE
SAN DIEGO CA 92121-
619-509-1171
VICKIS DESK (5)

PART #	QTY	DESCRIPTION	$PRICE	$EXTENDED	TAX
1421	1	ZEE IB[illegible]	26.75	26.75	T
0220	2	PHONE WIPES 18/BX	8.95	17.90	T

CABINET # 1 CABINET DESCRIPTION - VICKIS DESK

SUBTOTAL: 44.65

TAXABLE: .00

* SAFETY: .00
FIRST AID: 44.65
SUBTOTAL: 44.65
TAX 1: 3.47
TAX 2: .00

TOTAL 48.12

Your savings: 2.00

SIGNATURE: Vicki Shoemaker

PRINT NAME: VICKI SHOEMAKER

DATE: __/__/____

THANK YOU FOR YOUR BUSINESS. TERMS:NET 30 DAYS*

OFFICE COPY

PAYMENT DUE UPON RECEIPT
PLEASE PAY FROM THIS INVOICE

INVOICE

ZEE MEDICAL, INC.
PO BOX 4530
CHESTERFIELD MO 63006-4530
800-491-5024

PAGE 1
DATE 01/22/2004
TIME 09:28:01

MARC SOKOLOWSKI 32/057/65

ORDER/INVOICE# 140628218
P.O.#
TAX RATE1(T) 7.75
TAX RATE2(2) 0.00

BILL TO # 003993
WOMEN 1ST HEALTHCARE
5355 MIRA SORENTO PLACE
SAN DIEGO CA 92121-
619-509-1171

SHIP TO # 003993
WOMEN 1ST HEALTHCARE
5355 MIRA SORENTO PLACE
SAN DIEGO CA 92121-
619-509-1171

PART #	QTY	DESCRIPTION	$PRICE	$EXTENDED	TAX
0220	1	PHONE [illegible]	8.95	8.95	T
1418	1	ZEE PAIN-AID 250/BOX	20.55	20.55	T
1447	1	ANTACID, TRIAL 250/BOX (ZEE)	18.50	18.50	T
0795	1	URGENT QR, 2/PK	9.95	9.95	T
1459	1	CONGES[illegible]	12.30	12.30	T
1475	1	COLD-EEZE [illegible] CHERRY 20/BX	11.30	11.30	T
1420	1	ZEE IBUTAB 100/BOX	11.00	11.00	T

CABINET # 1 CABINET DESCRIPTION - BREAKROOM SUBTOTAL: 92.55

FIRST AID
SAFETY
TRAINING

		* SAFETY:	.00
		FIRST AID:	92.55
		SUBTOTAL:	92.55
TAXABLE:	92.55	TAX 1:	7.18
TAXABLE:	.00	TAX 2:	.00
		TOTAL	99.73

Ask about our
Workplace Safety Evaluation
Safety Resource Center
Training Calendar including
OSHA Compliance
Your preferred customer savings: 3.35
Online Reporting

SIGNATURE: V. Shoemaker DATE: 01/22/04

PRINT NAME: V. Shoemaker

THANK YOU FOR YOUR BUSINESS. TERMS:NET 30 DAYS*

For service,
Call 888-CALL-ZEE
Or visit www zeemedical com

OFFICE COPY

PAYMENT DUE UPON RECEIPT
PLEASE PAY FROM THIS INVOICE