UNITED STATES BANKRUPTCY COURT FOR THE DISTRICT OF DELAWARE

PROOF OF CLAIM

YOUR CLAIM IS SCHEDULED AS

s991

$34 27 Unsecured Contingent Disputed Unliquidated

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

06509940003615

STATE OF RHODE ISLAND
EDS FEDERAL CORPORATION
PO BOX 2006
WARWICK RI 02887 2006

Creditor Telephone Number 401) 784-3879

☐ 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

The amounts 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, 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

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 August 2004

1 BASIS FOR CLAIM

- ☐ Goods sold
- ☐ Services performed
- ☐ Money loaned
- ☐ Personal injury/wrongful death
- ☐ Taxes
- ☒ Other (describe briefly) Drug Rebate Invoices for mfg.64248
- ☐ 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 2/19/04, 5/18/04 & 8/30/04

3 IF COURT JUDGMENT, DATE OBTAINED

4 TOTAL AMOUNT OF CLAIM AT TIME CASE FILED $ ________ (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 $ 92.18 plus URA coorection for 2nd04

☒ 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 October 26, 2004 for Governmental Units

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
SEP 17 2004
BMC

Women First Healthcare Inc

00180

DATE SIGNED 9/13/04

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)

Helen G Vaughn

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

RUN DATE 07/02/2004

STATE OF RHODE ISLAND
DRUG REBATE
30 DAY PAST DUE NOTICE
MFG CODE 64248

PERIOD JUNE 2004

PAST DUE

ACCORDING TO OUR RECORDS, THE RHODE ISLAND DRUG REBATE PROGRAM SHOWS THAT THE AMOUNT BELOW HAS BEEN OUTSTANDING FOR THE INVOICE(S) LISTED FOR OVER 30 DAYS IT IS YOUR OBLIGATION TO PAY THE FULL AMOUNT OF REBATE FOR WHICH YOU HAVE NO DISPUTE WITHIN 30 CALENDAR DAYS AFTER RECEIVING THE RHODE ISLAND MEDICAID DRUG REBATE INVOICE PLEASE MAIL A COPY OF THIS LETTER ALONG WITH YOUR PAYMENT TO

EDS
P O BOX 2006
WARWICK, RI 02887-2006

PLEASE MAKE CHECKS PAYABLE TO THE STATE OF RHODE ISLAND WHEN MAILING IN A CHECK, PLEASE SPECIFY BELOW OR ON AN ATTACHED MEMO THE AMOUNT OF REBATE THAT SHOULD BE APPLIED TO EACH INVOICE IF ANY QUESTIONS SHOULD ARISE, PLEASE CALL ([illegible]

INV NUM	REBATE AMT	INV DATE	BALANCE DUE	INTEREST	NEW BALANCE DUE
0340292	$34 28	02/19/2004	$34 28	$0 00	$34 28
0410290	$57 90	05/18/2004	$57 90	$0 00	$57 90
				TOTAL PAST DUE	$92 18

MFR NAME WOMEN FIRST HEALTHCARE INC

MFR ADDRESS 12220 EL CAMINO REAL
SUITE 400

SAN DIEGO CA 92130

Questions or Comments Contact:
Julie Simpson
Julie.A.Simpson@eds.com
603-774-4107

RUN DATE 02/20/2004 MEDICAID DRUG REBATE INVOICE PERIOD CALENDAR YEAR 2003 4TH QUARTER

STATE CODE RI INV NUM 0340292
PERIOD COVERED 10/01/2003 THROUGH 12/31/2003

NDC	DRUG NAME	REBATE/UNIT	UNITS REIMB	REBATE AMT	NUM SCRIPTS	AMOUNT REIMB
64248 0117 10	BACTRIM DS	0 856900	40 0	$34 28	2	$68 98
		TOTAL	40 0	$34 28	2	$68 98

RUN DATE 05/18/2004 MEDICAID DRUG REBATE INVOICE PERIOD CALENDAR YEAR 2004 1ST QUARTER

STATE CODE RI INV NUM 0410290
PERIOD COVERED 01/01/2004 THROUGH 03/31/2004

NDC	DRUG NAME	REBATE/UNIT	UNITS REIMB	REBATE AMT	NUM SCRIPTS	AMOUNT REIMB
64248 0117 10	BACTRIM DS	0 933800	62 0	$57 90	5	$121 15
		TOTAL	62 0	$57 90	5	$121 15

RUN DATE 08/30/2004

MEDICAID DRUG REBATE INVOICE

PERIOD CALENDAR YEAR 2004 2ND QUARTER

STATE CODE RI INV NUM 0420298
PERIOD COVERED 04/01/2004 THROUGH 06/30/2004

NDC	DRUG NAME	REBATE/UNIT	UNITS REIMB	REBATE AMT	NUM SCRIPTS	AMOUNT REIMB
64248 0117 10	BACTRIM DS	0 000000	54 0	$0 00	3	$56 01
		TOTAL	54 0	$0 00	3	$56 01