PROOF OF POLICY CLAIM FORM [1]

Date: [_____]

Ambac Assurance Corporation,
as Management Services Provider of
the Segregated Account of Ambac Assurance Corporation
One State Street Plaza
New York, NY 10004
Attention: Claims Processing
Email: claimsprocessing@ambac.com
Facsimile: (212) 208-3404

Reference Policy Number: [_____]

Reference is made to (i) the Payment Guidelines for Plan of Rehabilitation Effective [ ] (the "Payment Guidelines"), (ii) the attached claim schedule, which includes detailed information about the Policy Claim made pursuant to this Proof of Policy Claim Form (the "Claim Schedule"), (iii) the Policy issued by Ambac Assurance Corporation ("Ambac"), identified above and on the Claim Schedule (the "Policy"), with respect to the Insured Obligation identified on the Claim Schedule, and (iv) the attached Allocation Schedule, which sets out the application of any Cash paid by the Segregated Account in respect of the preceding Policy Claim (if any) submitted by the Holder in respect of the Policy. Terms capitalized herein and not otherwise defined shall have the meanings ascribed to such terms in or pursuant to the Payment Guidelines or the Policy, as the case may be, unless the context otherwise requires.

The undersigned hereby certifies as follows:

1. The undersigned is a Holder under the Policy and is entitled, pursuant to the provisions of the Policy, to submit a Claim for the "Total Claim Amount" set forth on the Claim Schedule with respect to the Insured Obligations (the "Total Claim Amount").

2. The information set forth on the Claim Schedule and the Allocation Schedule is true, correct and complete.

3. The Total Claim Amount is due for Payment pursuant to the terms of the Policy and the Transaction Documents relating to or governing the Insured Obligation.

4. The undersigned has not previously made a Claim or demand for Payment under the Policy in respect of amounts due on the Insured Obligations on the "Distribution Date" indicated on the Claim Schedule, except as otherwise

[1] *All Policy Claims relating to the same Insured Obligation and Policy must be submitted using this Proof of Policy Claim Form (and Claim Schedule), with a separate Proof of Policy Claim Form (and Claim Schedule) being used for each Claim Period (as defined in the Claim Schedule).*

specified in an addendum to this Proof of Policy Claim Form submitted by the Holder herewith and[/or] as specified in the Claims or demands for Payment submitted to Ambac in the form specified by the Policy, copies of which are attached hereto pursuant to paragraph 7.

5. [*Complete for the first Policy Claim made after the Effective Date in respect of the Policy or if the Holder wishes to alter the payment instructions previously provided to the Management Services Provider:* The undersigned hereby requests that any portion of the Total Claim Amount to be paid by the Segregated Account in Cash be made to the following account by bank wire transfer of federal or other immediately available funds:

Bank Name: [_____]
ABA #: [_____]
Acct #: [_____]
Reference: [_____]

OR *If the Holder has provided account details previously and these are not changing, please include the following:* The undersigned hereby requests that any portion of the Total Claim Amount to be paid by the Segregated Account in Cash be paid by bank wire transfer of federal or other immediately available funds to the account notified by the undersigned to the Segregated Account and the Management Services Provider pursuant to the Proof of Policy Claim Form dated as of [ ] and relating to the Policy.]

6. [*Complete the following if the Holder is a Trustee and/or agent for the Beneficial Holder of the Insured Obligation:*] The undersigned hereby agrees and confirms that, following receipt of any Cash Payment by the Segregated Account in respect of the Total Claim Amount, (A) it shall (i) cause such funds to be distributed in accordance with the provisions of the Transaction Documents relating to the Insured Obligations, and (ii) maintain an accurate record of such distributions with respect to the Insured Obligations and the corresponding Claim on the Policy and proceeds thereof, and (B) the Cash paid by the Segregated Account in respect of the preceding Policy Claim (if any) submitted by the Holder in respect of the Policy was applied as set forth in the Allocation Schedule.

7. [*If the Policy requires the Holder to submit a claim or demand for payment in a specified form or to have satisfied certain conditions, include the following:*] [The undersigned has duly completed and submitted to Ambac a claim or demand for Payment in the form specified by the Policy, a copy of which is attached hereto, and all other conditions to the receipt of the Total Claim Amount have been satisfied, and the amount claimed therein is equal to the Total Claim Amount.]

Without prejudice to (i) the terms and provisions of the Policy and any other related Transaction Documents and (ii) any assignment previously executed, whether pursuant to a Proof of Policy Claim Form or otherwise, the undersigned [*include the following, if applicable:*]

[, in its capacity as Trustee and on behalf of the Beneficial Holders of the Insured Obligation], hereby assigns to Ambac all of its rights, title and interests [*include the following, if applicable:*] [, including rights, title and interests held by it on behalf of the Beneficial Holders of the Insured Obligation,] with respect to the Insured Obligations, to the extent of any Payments by the Segregated Account with respect to such Insured Obligations; the foregoing assignment is in addition to, and not in limitation of, rights of subrogation and/or reimbursement otherwise available to Ambac or the Segregated Account in respect of such Payments. The undersigned shall take such action and deliver such instruments as may be reasonably requested or required by Ambac or the Segregated Account to effectuate the purpose or provisions of the foregoing assignment.

Any oral or written communications to the Holder in respect of this Proof of Policy Claim Form and the Policy Claim made hereunder may be addressed to one of the following persons:

1. [*insert name*], [*address*], [*phone number*] and [*email*]

2. [*insert name*], [*address*], [*phone number*] and [*email*][2]

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD THE SEGREGATED ACCOUNT, THE REHABILITATOR OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE SUBJECT TO CIVIL AND/OR CRIMINAL PENALTY.

[ ],
as Holder

By: _____
Name:
Title:

[2] *Contact details for at least 2 persons at the Holder must be provided. At least 1 contact person must be authorized to discuss operations and settlement matters. The person responsible for operations/settlements should be clearly identified.*

	CLAIM SCHEDULE			
Holder:				
Deal name:				
Policy #:				
Payment Date:*				
Claim Period:**				
Total Claim Amount:				
Insured Obligations				
(including CUSIP, if any)	**Principal Claim Amount**	**Interest Claim Amount**	**Total Claim Amount**	
Total				
*Payment Date is the date on which principal and/or interest is due for payment with respect to the Insured Obligation.				
**Claim Period is the period in respect of which Payments are due on the Payment Date.				
Please use a different Proof of Policy Claim Form and Claim Schedule for each Payment Date.				

POLICY CLAIM PAYMENT - ALLOCATION SCHEDULE

Holder:
Deal name:
Policy #:

Total Claim Amount for Policy Claim:
Cash received in respect of Policy Claim:
Claim Period*:
Payment application date**:

Insured Obligations by CUSIP (if applicable):	**Payment applied against Principal:**	**Payment applied against Interest:**	**Total Claim Payment applied:**
XXXXX			
XXXXX			
Total			

* Claim Period is the period in respect of which the Policy Claim was submitted pursuant to the Claim Schedule. For a Deferred Payment, the Claim Period can be identified as "Deferred Payment."

**Payment application date is the date the Policy Claim Payment was paid by the Holder to the Beneficial Holders.

The Holder hereby certifies that the information contained in this Allocation Schedule to be true, correct and up-to-date.

_____
For and on behalf of
[INSERT NAME OF HOLDER]
Name:
Title:
Date: