PROOF OF LVM POLICY CLAIM FORM

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: 17548BE

Reference is made to (i) the LVM Payment Guidelines for Plan of Rehabilitation, as amended (the "LVM Payment Guidelines"), (ii) the attached claim schedule, which includes detailed information about the LVM Policy Claim(s) made pursuant to this Proof of LVM Policy Claim Form (the "Claim Schedule") and (iii) the LVM Policy with respect to the Insured Obligation(s) identified on the Claim Schedule. Terms capitalized herein and not otherwise defined shall have the meanings ascribed to such terms in or pursuant to the LVM Payment Guidelines or the LVM Policy, as the case may be, unless the context otherwise requires.

The undersigned hereby certifies as follows:

1. The undersigned is the trustee (the "LVM Trustee") under the Senior Indenture dated as of September 1, 2000 by and between the Director of the State of Nevada Department of Business and Industry and Wells Fargo Bank, N.A., as trustee (as amended, modified and supplemented from time to time, the "Indenture") and, pursuant to the LVM Payment Guidelines, is entitled to submit a Claim for the "Total Claim Amount" set forth on the Claim Schedule with respect to the Insured Obligation (the "Total Claim Amount").

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

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

4. The undersigned has not previously made a Claim or demand for Payment under the LVM Policy in respect of amounts due on the Insured Obligation(s) on the "Payment Date" indicated on the Claim Schedule.

5. [*Complete for the first LVM Policy Claim made after the Effective Date in respect of the LVM Policy or if the LVM Trustee 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 LVM Trustee 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 LVM Policy Claim Form dated as of [ ] and relating to the LVM Policy.]

6. The undersigned hereby agrees that, following receipt of any Cash Payment by the Segregated Account in respect of the Total Claim Amount, it shall (i) cause such funds to be distributed to the LVM Holders who, but for the LVM Payment Guidelines, would have been entitled to submit LVM Policy Claims to the Segregated Account in respect of the Total Claim Amount, (ii) maintain an accurate record of such distributions with respect to the Insured Obligation and the corresponding Claim on the Policy and proceeds thereof, and (iii) comply with the terms of the Indenture insofar as they relate to such funds following Payment by the Segregated Account, including, without limitation, noting the rights of the Segregated Account and/or Ambac Assurance Corporation ("Ambac") in the bond register.

Nothing contained herein shall, or shall be deemed to, alter, transfer, impede, impair, restrict, limit, prejudice, waive, delay or otherwise affect any rights of Ambac or the Segregated Account under or in connection with the LVM Policy or any other Transaction Documents relating to the LVM Policy, whether contractual, by way of subrogation or otherwise, including, without limitation, all subrogation rights available to Ambac or the Segregated Account in connection with any Payment under the LVM Policy.

Any oral or written communications to the undersigned in respect of this Proof of LVM Policy Claim Form and the LVM Policy Claims 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*][1]

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[1] *Contact details for at least 2 persons at the LVM Trustee 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.*

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 LVM Trustee

By: ______________________________
Name:
Title:

LVM CLAIM SCHEDULE

LVM Trustee:				
Policy #:	**17548BE**			
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 LVM Policy Claim Form and LVM Claim Schedule for each Payment Date.

LVM POLICY CLAIM PAYMENT - ALLOCATION SCHEDULE

LVM Trustee:
Policy #: 17548BE

Total Claim Amount for LVM Policy Claim:
Cash received in respect of LVM 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 LVM Policy Claim was submitted pursuant to the LVM Claim Schedule.
For a Deferred Payment, the Claim Period can be identified as "Deferred Payment."

**Payment application date is the date the LVM Policy Claim Payment was paid by the LVM Trustee to the LVM Holders.

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

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For and on behalf of
______________________________, LVM Trustee
Name:
Title:
Date: